Virginia's Addiction Treatment Services Delivery System Transformation

Concept Paper: 1115 Waiver for Addiction Treatment Services

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Department of Medical Assistance Services

Concept Paper: Proposed 1115 Waiver for Addiction Treatment Services

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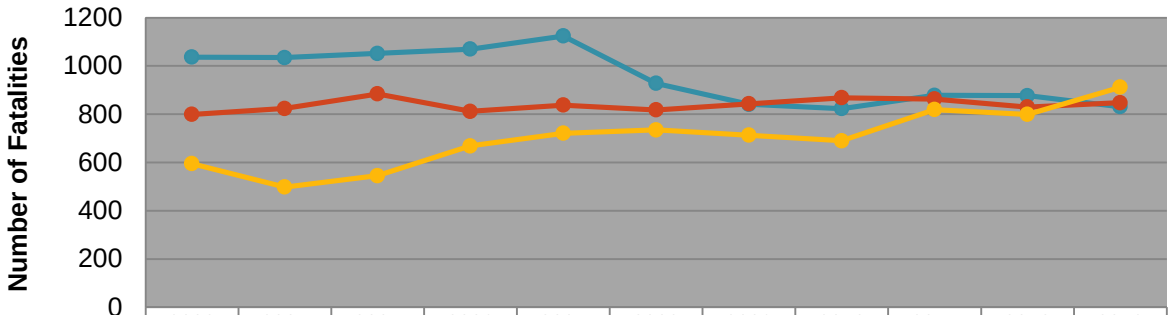
Executive Summary

Virginia is experiencing a substance use crisis of overwhelming proportions. In 2014, 986 people died due to fatal drug overdoses. More Virginians died from drug overdose than car accidents or homicides in 2013 (see Table 1 below). Nearly 80% of these deaths involved prescription opioids or heroin.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Motor Vehicles	1037	1035	1052	1070	1124	928	841	823	878	877	831
Guns	799	824	884	812	838	818	843	868	863	830	848
Drug/Poisons	595	498	545	669	721	735	713	690	819	799	912

Table 1: Drug Fatalities in Virginia

Virginia's 1.1 million Medicaid members are disproportionately impacted by the substance use epidemic. The Virginia Department of Medical Assistance Services (DMAS) identified 216,555 members with a claim that included a substance use disorder (SUD) diagnosis in state fiscal year 2015 (see Figure 1). The financial impact is nearly as great as the human cost. Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments in 2014.

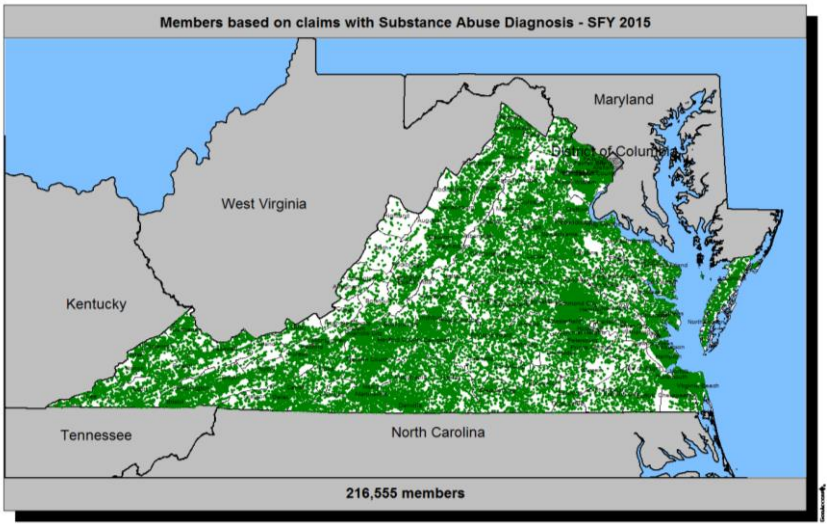


Figure 1: Virginia Medicaid Members with Claims with a SUD Diagnosis, SFY2015

In response to the epidemic, Governor Terry McAuliffe created a bipartisan Task Force on Prescription Drug and Heroin Addiction. This Task Force issued dozens of recommendations to address prescription drug abuse and opioid use disorder. A major recommendation was to increase access to treatment for opioid addiction for Virginia's Medicaid members by increasing Medicaid reimbursement rates.

To implement this recommendation, DMAS worked with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to develop a comprehensive Medicaid SUD Treatment Benefit. This benefit expands short-term inpatient detox and residential treatment to all Medicaid members, significantly increases rates for the full continuum of community-based addiction treatment services, and adds a new peer support service to support long-term recovery (see Figure 2). Furthermore, this benefit promotes a comprehensive transformation of Virginia's SUD delivery system by "carving in" the community-based addiction treatment services into Managed Care Organizations (MCOs) to promote full integration of physical health, traditional mental health, and addiction treatment services. This benefit was included in the Governor's budget and passed the General Assembly with strong bipartisan support.

Figure 2: Medicaid SUD Treatment Benefit Passed by Governor & General Assembly, March 2016

To ensure the successful implementation of the Medicaid SUD Treatment Benefit on April 1, 2017, DMAS seeks a SUD Delivery System Transformation 1115 Demonstration Waiver. The waiver is essential to achieving the expansion of residential treatment capacity required to meet the needs of Virginia's Medicaid population.

Under this demonstration, Virginia will pursue a broad and deep transformation of the Commonwealth's delivery system to ensure a comprehensive continuum of addiction treatment based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria including withdrawal management, short-term inpatient and residential treatment, partial hospitalization, intensive outpatient treatment, outpatient treatment including Medication Assisted Treatment (MAT), and long-term recovery supports. DMAS is partnering with DBHDS and MCOs to ensure that licensing aligns with ASAM, SUD providers are credentialed using ASAM criteria, and providers are trained to deliver addiction treatment services with fidelity to ASAM criteria.

Virginia will also use the demonstration to support reforms and practice changes including:

- promoting strategies to identify individuals with SUD;
- disseminating evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and MAT;
- increasing use of quality and outcome measures and developing value-based payment models with the MCOs;
- developing innovative care coordination models to link individuals to SUD providers, primary care, community resources, and long-term recovery support services and ensure seamless care transitions between different levels of SUD care and primary care;

- implementing strategies to address prescription drug abuse and opioid use disorders including promoting the CDC Opioid Prescribing Guidelines;
- increasing the MAT provider workforce through intensive education and training statewide; and
- conducting a robust evaluation with outside academic experts to assess the impact of the demonstration.

By funding the Medicaid addiction treatment services benefit, Virginia's Governor and General Assembly have demonstrated the bipartisan commitment to creating one of the most comprehensive Medicaid addiction treatment benefits in the country. The benefit will provide the full continuum of treatment needed to address the substance use crisis and reverse the opioid epidemic. This waiver is the critical next step needed to ensure the success of Virginia's addiction treatment delivery system transformation in expanding access to the treatment services that will save lives, improve patient outcomes, and decrease costs.

Transforming the Delivery System of Addiction Treatment Services

Current Delivery System

The Virginia Medicaid program covers approximately 1.1 million individuals: 80% of members receive care through contracted Managed Care Organizations (MCOs) and 20% of members receive care through Fee-for-Service (FFS). The majority of members enrolled in Virginia's Medicaid program includes children, pregnant women, parents, and the Aged, Blind, and Disabled. Within the current system, non-traditional community-based addiction treatment services are "carved out" of the MCOs and managed by Magellan, the Medicaid Behavioral Health Service Administrator (BHSA). For members enrolled in FFS, Magellan covers all traditional and non-traditional addiction treatment services. The non-traditional services include:

- Residential Treatment,
- Opioid Treatment,
- Substance Abuse Day Treatment,
- Crisis Intervention,
- Intensive Outpatient Treatment,
- Substance Abuse Case Management, and
- Peer Supports.

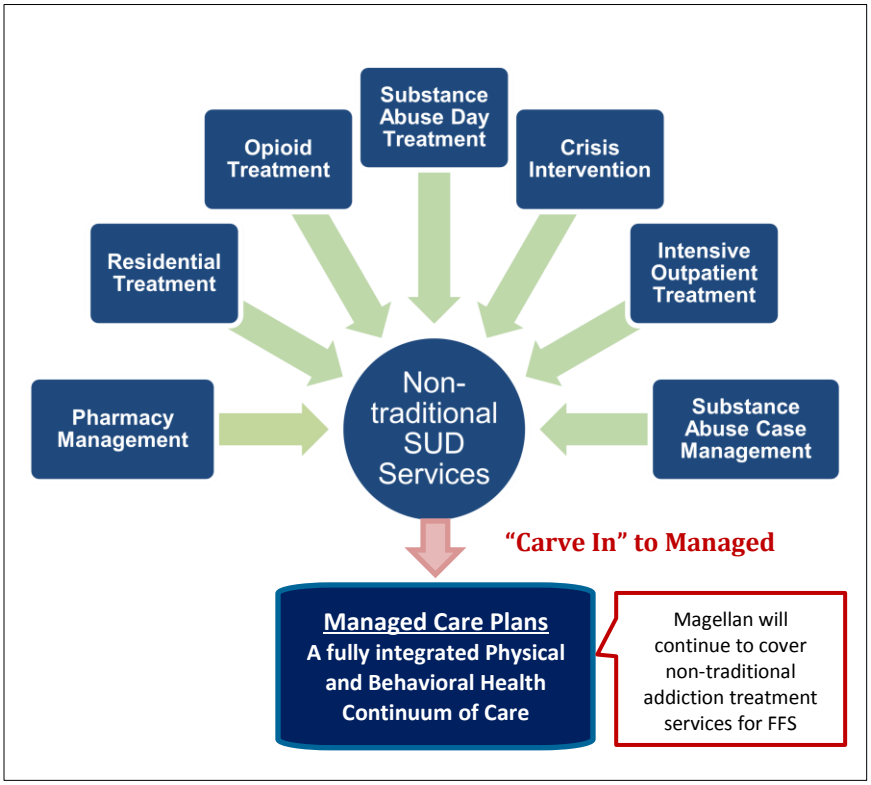


Figure 3: Transformed SUD Services System

The "carve out" of the community-based addiction treatment services from MCOs contributes to Virginia's historically fragmented system in which community-based addiction treatment services are delivered in separate siloes from mental health and physical health services. Providers who deliver these services have complained that the rates are lower than the cost of providing care and have struggled to understand who to bill for services. Patients have struggles to understand where to seek services. Furthermore, the rate structure for addiction treatment services has not been adjusted since 2007 when Virginia Medicaid first started reimbursing for addiction treatment services. Low Medicaid reimbursement rates have severely limited the number of providers willing to provide these services to Medicaid members and resulted in inadequate access to treatment. Virginia Medicaid only spent approximately $2 million on community-based addiction treatment services in State Fiscal Year 2015 and served an average of 734 people per month, demonstrating the underutilization of these services.

Transformed Addiction Treatment Service System under the Waiver

To address the fragmentation and siloes, Virginia sought the authority to fully integrate physical and behavioral health services for individuals with SUD and expand access to the full continuum of services. DMAS obtained approval from the Governor and General Assembly to "carve in" community-based addiction treatment services into managed care for members who are already enrolled in MCOs as illustrated in Figure 3.

Since the MCOs already manage all the physical health services as well as the inpatient services, outpatient services, and medications for mental health and substance abuse, "carving in" the community-based addiction treatment services will allow them to provide members with the full continuum of addiction treatment services based on their level of need and to integrate the addiction treatment services with physical health and traditional mental health treatment services. Magellan will continue to cover these services for those Medicaid members who are enrolled in FFS.

The SUD waiver is necessary to provide Virginia the authority to provide short-term inpatient detox and residential substance abuse treatment in facilities with greater than sixteen beds. The waiver will allow Virginia providers to expand their residential treatment capacity to meet the needs of Virginia's Medicaid population. Residential treatment services will be integrated and coordinated with the full continuum of addiction treatment services. Seamless care transitions will occur from residential treatment to lower levels of care such as intensive outpatient and outpatient treatment with Medication Assisted Treatment and long-term recovery supports available to all Medicaid members.

SUD Treatment Service	Current	SFY 17	SFY 18
Inpatient Detox – All Adults	0	24	47
Residential Treatment – Non-Pregnant Adults	0	122	534
Residential Treatment – Pregnant Women	84	157	269
Day Treatment/Partial Hospitalization – Pregnant & Non-Pregnant Adults	42	50	64
Intensive Outpatient – All Adults	690	818	1047
Opioid Treatment (Medication Assisted Treatment) – All Adults	552	654	837
Case Management – All Adults	1101	1250	1618
Peer Supports – All Adults	0	822	2839

Note: Numbers indicated are likely an under-representation of members who will require services in the first two years of the demonstration. Significant increases in provider capacity will be required over several years, especially in residential treatment, Medication Assisted Treatment, and peer recovery supports.

Table 2: Estimated Addiction Treatment Services Enrollment

The estimated number of Medicaid members who will receive services under the new addiction treatment services benefit in State Fiscal Years 2017 and 2018 is illustrated in Table 2. While a far greater number of Medicaid members have a substance use disorder than the numbers in this table, these estimates account for the current limited treatment capacity and the time that providers will require to expand new addiction treatment services.

Goals and Objectives of the Addiction Treatment Service Benefit

Virginia's overall goal for the addiction treatment services benefit is to achieve the Triple Aim of improved quality of care, improved population health, and decreased costs for the Medicaid population with SUD. DMAS' specific objectives for this benefit are outlined below in Figure 4.

Improve quality of care and population health outcomes for the Medicaid population.	• Improve quality of addiction treatment (as measured by performance on identified quality measures). • Reduce prescription opioid drug abuse (measured by Pharmacy Quality Assurance opioid performance measures). • Decrease fatal and non-fatal drug overdoses among Medicaid members.
Increase Medicaid members' access to and utilization of community-based and outpatient addiction treatment services.	• Increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering addiction treatment services to Medicaid members. • Increase the quantity of community-based and outpatient addiction treatment services used by Medicaid members with SUD.
Decrease utilization of high-cost Emergency Department and hospital services by Medicaid members with SUD.	• Decrease ED visits, inpatient admissions, and readmissions to the same level of care or higher for a primary diagnosis of SUD. • Decrease inappropriate utilization for other physical and behavioral health care services for other conditions such as chronic diseases and serious mental illness.
Improve care coordination and care transitions for Medicaid members with SUD.	• Improve the coordination of addiction treatment with other behavioral and physical health services. • Improve care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum and linkages with primary care upon discharge.
Increase the number and type of health care clinicians providing SUD services to Medicaid members with SUD.	• Increase number of addiction treatment providers providing all ASAM Levels of Care in each region of the Commonwealth. • Increase the number of buprenorphine-waivered physicians and the number of physicians providing Medication Assisted Treatment. • Increase the number of clinicians with substance abuse training and the number of behavioral health clinicians providing addiction treatment .

Figure 4: Addiction Treatment Service Waiver Objectives

Comprehensive Evidence-Based Benefit Design

Overview of Benefit

DMAS and DBHDS designed a comprehensive addiction treatment benefit that guarantees access to a full continuum of evidence-based best practices designed to address the immediate and long-term physical,

mental and SUD care needs of all Medicaid members. This benefit was approved by the Governor and General Assembly in the 2016 legislative session. It includes the full spectrum of addiction treatment services, including short-term inpatient and short-term residential addiction treatment services for individuals in Institutes for Mental Disease (IMDs) of unlimited bed size, which will supplement and coordinate with community-based services and supports including partial hospitalization, intensive outpatient programs, outpatient services including Medication Assisted Treatment (MAT), crisis intervention, case management, and peer recovery supports.

To increase access to community-based services and supports, the benefit includes significant reimbursement rate increases ranging from 50% to 400% to align Medicaid rates with, or even exceed, commercial reimbursement rates. The benefit will improve use of evidence-based practices, including SBIRT, withdrawal management, MAT, care coordination, and peer recovery supports and services.

The comprehensive addiction treatment benefit approved by the Governor and General Assembly includes the following core components:

- **Expanded coverage of inpatient detox and inpatient substance abuse treatment** (ASAM Level 4.0) for up to 15 days for all Medicaid members (previously only available to children).

- **Expanded coverage of residential detox and residential substance abuse treatment** (ASAM levels 3.1, 3.3, 3.5, and 3.7) for all Medicaid members (previously delivered using outdated, state-defined program rules).

- **Increased rates for existing substance abuse treatment services** currently covered by Medicaid by 50% for Substance Abuse Case Management and by 400% for Substance Abuse Partial Hospitalization (ASAM Level 2.5), Substance Abuse Intensive Outpatient (ASAM Level 2.1), and Opioid Treatment – counseling component of MAT to align with current industry standards.

- **Added coverage of Peer Supports for individuals with SUD and/or mental health conditions.** Reimbursement will be provided for peers certified by DBHDS who will provide intensive recovery coaching to individuals with SUD at all ASAM Levels of Care and to those who need long-term recovery supports.

The comprehensive Medicaid addiction treatment benefit is a transformative redesign of the Virginia Medicaid benefit for individuals with SUD that fully aligns with CMS expectations for comprehensive, evidence-based benefit design. The major changes under the benefit are illustrated below in Table 3.

Addiction Treatment Service	Children < 21	Adults*	Pregnant Women
Traditional Services			
Inpatient (ASAM Level 4.0)	E	Added	Added
Outpatient (ASAM Level 1.0)	E	E	E

Addiction Treatment Service	Children < 21	Adults*	Pregnant Women
Medication Assisted Treatment – medication component	E	E	E
Non-Traditional Services			
Residential (ASAM Levels 3.1, 3.3, 3.5, and 3.7)	X	Added	50% rate increase
Partial Hospitalization (ASAM Level 2.5)	400% rate increase	400% rate increase	400% rate increase
Intensive Outpatient (ASAM Level 2.1)	400% rate increase	400% rate increase	400% rate increase
Opioid Treatment – counseling component of MAT (ASAM Level 1.0)	400% rate increase	400% rate increase	400% rate increase
Crisis Intervention	X	X	X
Case Management	50% rate increase	50% rate increase	50% rate increase
Peer Recovery Coaching (DBHDS certified peers)	Added**	Added**	Added

X = service was previously covered.
Added = service will be covered under the comprehensive addiction treatment benefit passed by the General Assembly starting on April 1, 2017. Rate increases were also included in addiction treatment benefit and will take effect on April 1, 2017.
* Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare.
** Peer support services for adults and family support partners for children and families will be added when the Virginia Department of Behavioral Health and Developmental Services finalizes the peer certification standard and DMAS is able to ensure that CMS requirements are met for Peer Support Services.

Table 3: Changes under Comprehensive Medicaid Addiction Treatment Benefit Passed by Governor & General Assembly in March 2016

Medical Criteria for Addiction Treatment Services Benefit

In order to receive services, the member must be enrolled in Virginia Medicaid and must meet the following medical necessity criteria:

- Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).

- Must meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM Criteria.

- If applicable, must meet the ASAM adolescent treatment criteria. *NOTE: Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to*

receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in this addiction treatment services demonstration will override any EPSDT requirements.

Determination of Medical Need based on ASAM Criteria for Addiction Treatment Services Benefit

The MCOs and Magellan will hire SUD Care Coordinators who are Licensed Practitioners of the Healing Arts including Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Nurse Practitioners, or Registered Nurses with substance abuse experience and the necessary competencies to use the ASAM Patient Placement Criteria. The SUD Care Coordinator or a licensed physician or Medical Director employed by the MCO or BHSA will perform an independent assessment of requests for all SUD residential treatment services (ASAM Levels 3.1, 3.3, 3.5, 3.7) using member information transmitted by providers via a uniform service review request form with attached clinical documentation (see *Appendix A).* The MCOs and Magellan will use the ASAM Criteria to perform a multidimensional assessment of members, place members at appropriate levels of care, and make recommendations for length of stay in the residential treatment setting.

Reimbursement Structure

A detailed description of the addiction treatment services reimbursement structure in included as *Appendix B.*

Standards of Care

The Virginia General Assembly in the 2016 Session directed DMAS to amend the state plan and/or seek federal authority to provide coverage for specific addiction treatment services and provided DMAS the authority to implement this change prior to the completion of any regulatory process undertaken in order to effect such change. Application for this 1115 waiver provides Virginia an effective vehicle for comprehensive revisions to its Addiction Treatment Services Benefit. Through revision of its contract requirements for MCOs and Magellan, State Plan, state regulations, and provider manuals, DMAS will establish standards of care for addiction treatment services that incorporate industry standard benchmarks from ASAM for defining medical necessity criteria, covered services, and provider qualifications. A timeline for completion of draft and final revisions to the State Plan, regulations, and provider manuals is included as *Appendix C.*

Addiction Treatment Services Continuum and ASAM Criteria

DMAS is aligning definitions of all community-based addiction treatment services with ASAM criteria, including the new inpatient detox and residential addiction treatment services as well as all other existing addiction treatment modalities and levels of care. DMAS convened a SUD Core Workgroup comprised of representatives from all key state health agencies including DBHDS, the Virginia Department of Health, and Virginia Department of Health Professions; Chief Medical Officers (CMOs) from all the MCOs and Magellan; addiction medicine experts; and representatives from public and private behavioral health providers, Federally Qualified Health Centers (FQHCs), hospitals, peer organizations, and consumers to provide recommendations

on the design and implementation of the Medicaid addiction treatment services benefit and ensure alignment with ASAM criteria (see Table 4).

ASAM Level of Care	Service Title	Brief Description	Is this an existing Medicaid Service?	Is this a new Medicaid service?
N/A	SUD Case Management	Assists children, adults, and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational services and other supports essential to meeting basic needs.	Yes	No
N/A	Crisis Intervention	Immediate care due to acute dysfunction requiring immediate clinical attention to prevent exacerbation of condition, prevent injury to member or other and provide treatment in least restrictive setting.	Yes	No
1	Outpatient Services	Organized outpatient treatment services of fewer than 9 hours per week delivered in a variety of settings. Services include professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.	Yes	No
1	Peer Recovery Supports	Peer provided support services for adults, adolescents and family support partner services to impacted family members to initiate clinical service utilization and self-determination strategies. Peer Providers have supervisory arrangement with licensed clinicians and certification by DBHDS. Peers may work under supervision, in a variety of service settings.	No	Yes
2.1	SUD Intensive Outpatient	Structured program delivering 9-19 hours per week, before/after work/school, in evening and/or weekends to meet complex needs of people with addition and co-occurring conditions. Arranges medical and psychiatric consultation, psycho-pharmacological consultation, addiction medication management and 24-hour crisis services.	Yes	No
2.5	SUD Partial Hospitalization	20 or more hours of clinically intensive programming per week with a planned format of individualized and family therapies. Service includes: direct access to psychiatric, medical, laboratory and toxicology services, MD consult within 8 hours by phone and 48 hours in person, Emergency Services available 24/7, and coordination with more and less intensive levels of care and supportive housing.	Yes	No
3.1	Clinically Managed Low Intensity Residential Services	Supportive living environment with 24-hour staff and integration with clinical services; at least 5 hours of low-intensity treatment per week.	No	Yes
3.3	Clinically Managed Population-Specific High Intensity Residential Services	Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed MH professionals.	No	Yes
3.5	Clinically Managed High Intensity Residential Services	Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents. Staffed by licensed/credentialed clinical staff including addiction counselors, LCSWs, LPCs, physicians/physician extenders, and credentialed MH professionals.	No	New model; Services expanded to all Medicaid adults

ASAM Level of Care	Service Title	Brief Description	Is this an existing Medicaid Service?	Is this a new Medicaid service?
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit. 24 hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.	Yes, for pregnant women and available under EPSDT for adolescents	Yes
4	Medically Managed Intensive Inpatient	Acute care general or psychiatric hospital with 24/7 medical management and nursing supervision and counseling services 16 hours/day. Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of additions.	No	Yes
1 WM	Ambulatory Withdrawal Management Without Extended On- Site Monitoring	Ambulatory withdrawal management without extended on-site monitoring with specialized psychological and psychiatric consultation and supervision.	No	Yes
2 WM	Ambulatory Withdrawal Management With Extended On- Site Monitoring	Ambulatory withdrawal management with extended on-site monitoring with clinical (medical) consultation and supervision.	No	Yes
3.2 WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24 hour support to complete withdrawal management and increase likelihood of continuing recovery	No	Yes
3.7 WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24 hour nursing care and physician visits as necessary, unlikely to complete withdrawal management without medical, nursing monitoring	No	Yes
4 WM	Medically Managed Intensive Inpatient Withdrawal Management	Severe, unstable withdrawal and needs 24 hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability	No	Yes
OTP	Opioid Treatment Program	Physician supervised daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opiate use disorder	Yes	No

Table 4: Redesigned, Evidence-Based Virginia Medicaid Benefit for Individuals with SUD and Alignment with ASAM Criteria

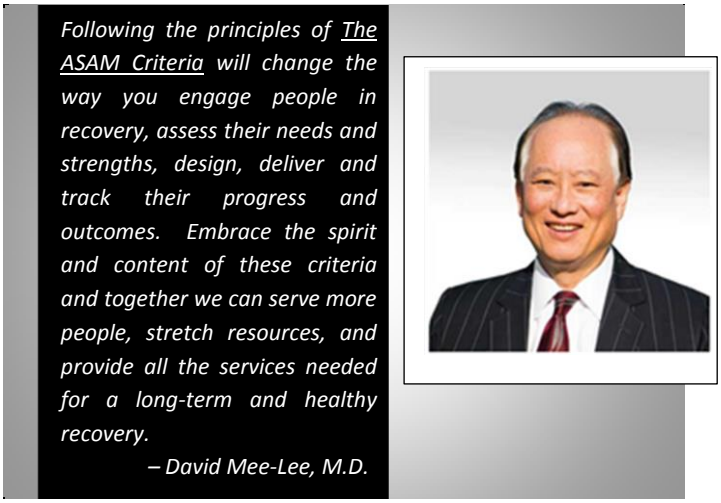
Addiction Treatment Services Providers and ASAM Criteria

DMAS will require that providers of addiction treatment services meet ASAM Criteria prior to participating in the Medicaid program. DMAS contracts with the MCOs and Magellan will stipulate that they must maintain provider credentialing requirements compliant with ASAM criteria. Virginia has ensured that its provider licensing requirements are consistent with ASAM criteria and, through future provider manual revisions (see *Appendix C*), will ensure all provider requirements are compliant with ASAM criteria. See *Appendix D* for a detailed comparison of ASAM key elements by level of care and DBHDS licensing requirements. Table 5 illustrates the crosswalk between ASAM level of care and Virginia's licensing standards:

ASAM LOC	ASAM Description	Licensing Standard
2.1	Intensive Outpatient Treatment	• Substance Abuse Intensive Outpatient Service For Adults, Children, and Adolescents
2.5	Partial Hospitalization Treatment	• Substance Abuse Partial Hospitalization or Substance Abuse/Mental Health Partial Hospitalization
3.1	Clinically Managed Low Intensity Residential Services	• Mental Health & Substance Abuse Group Home Service for Adults or Children • Substance Abuse Halfway House for Adults
3.3	Clinically-Managed, Population-Specific High Intensity Residential Services for Special Populations with Cognitive Disabilities	• Supervised Residential Treatment Services for Adults • Substance Abuse Residential Treatment for Adults
3.5	Clinically-Managed, Medium/High Intensity Residential Treatment	• Substance Abuse Residential Treatment Services for Adults or Children • Psychiatric Unit
3.7	Medically-Monitored Intensive Inpatient Treatment	• Psychiatric Unit within an acute care general hospital • Acute/Freestanding psychiatric hospital –with a Medical Detox license; • Substance Abuse Residential Treatment Services for Adults or Children with a Medical Detox license; • Residential Crisis Stabilization Units with a detox license
4.0	Medically-Managed Intensive Inpatient Treatment	• Acute care general hospital - 12-VAC5-410

Table 5: Licensing Standards by ASAM Level of Care

Through collaboration with DBHDS, MCOs, and Magellan, DMAS will ensure implementation of a comprehensive plan of workforce development to ensure providers are knowledgeable and capable to deliver effective, evidenced based SUD practices across all ASAM levels of care. Partnering with DBHDS, DMAS will implement a robust statewide training program to ensure that addiction treatment service workforce members obtain an in-depth understanding of ASAM criteria through live training with Dr. David Mee-Lee, Chief Editor of *The ASAM Criteria*. DBHDS will organize a series of two day ASAM trainings across the state led by Dr. Mee-Lee that will be widely promoted by DMAS and DBHDS to all public and private behavioral health providers. These trainings will provide participants with opportunities for practice applying ASAM criteria at every stage of the addiction treatment process: assessment, engagement, treatment planning, continuing care, and discharge or transfer. Providers will also have access to the ASAM e-Training series and a variety of webinars that educate clinicians, counselors and other professionals involved in standardizing assessment, treatment and continued care. These trainings will help ensure that providers fully understand the ASAM criteria and support them in aligning their existing and new treatment services with ASAM requirements for all Levels of Care.



Assessment and ASAM Patient Placement Criteria

Through MCO and Magellan contract requirements, regulations, and provider manuals, DMAS will require that assessment for all addiction treatment services, level of care and length of stay recommendations will be based upon ASAM Patient Placement Criteria ensuring a multidimensional assessment of beneficiaries and placement of beneficiaries at appropriate levels of care. For residential treatment services, MCO and Magellan Care Coordinators will use ASAM to perform independent assessments to determine level of care and length of stay recommendations. The Virginia Association of Health Plans will offer training with Dr. Mee-Lee to all the MCO care coordinators, physicians, and CMOs to ensure they gain competency in use of the ASAM patient placement criteria.

MCOs and Magellan Care Coordinators will conduct service authorizations and will proactively monitor utilization by members to identify complex needs, gaps in services, and overlapping services that may reflect duplication of interventions. The use of ASAM Patient Placement Criteria will be documented by all MCOs, Magellan, and providers by using a uniform service review request form (see *Appendix A).*

Network Development Plan

DBHDS will license providers and MCOs and Magellan will credential providers based on their ability to deliver services consistent with ASAM criteria and provide evidence-based SUD practices. DBHDS will also certify the

individuals providing peer support services. MCOs and Magellan will build networks of health systems, community service boards (public behavioral health providers), FQHCs, and providers in each region who will be licensed by DBHDS and credentialed by MCOs and Magellan. MAT providers will be developed and will receive coordinated training and education to enhance the delivery of evidence-based MAT services based on ASAM criteria. MCOS and Magellan will build networks with certified peer recovery coaches to provide long-term recovery services and supports after acute treatment.

DMAS analyzed the existing number of service providers by region and ASAM level of care as well as the number of Medicaid members with identified SUD (see table below). DMAS recognizes the need to increase network adequacy by increasing the number of its addiction treatment service providers, especially residential treatment providers.

ASAM Level of Care:	2.1	2.5	3.1	3.3 & 3.5	3.7	4	Total Providers	Total Members
Region:								
Central Region	25	24	0	4	10	27	90	5958
Charlottesville Region	6	5	2	2	4	7	26	1801
Far Southwest Region	13	14	1	6	6	36	76	4765
Halifax/Lynchburg Region	8	8	1	6	4	6	33	1865
Northern/Winchester Region	32	25	7	10	13	19	106	2674
Roanoke/Alleghany	21	20	3	5	10	16	75	3566
Tidewater Region	23	22	4	11	15	24	99	4497
	128	**118**	**18**	**44**	**62**	**135**	**505**	**25,126**

Table 6: Existing Providers and Members with Primary SUD Diagnosis by Region

DMAS seeks CMS approval of the 1115 waiver for addiction treatment services six to eight months prior to its proposed April 1, 2017 implementation date to enable providers with sufficient opportunity to increase bed capacity to deliver ASAM compliant residential programs. Following approval of the 1115 waiver, each MCO and Magellan will submit a comprehensive network development plan to DMAS. DMAS recognizes that there may still be challenges with achieving network adequacy in certain regions in the first year of implementation due to the lack of providers. DMAS will not consider plans to be in violation of their contract if they do not have a specific provider type in a region because those providers do not exist and if they have exhausted all providers in the State, both in and out of their networks.

To address the Commonwealth's current lack of provider infrastructure for addiction treatment services, DMAS will implement the following plan:

- ⇒ Each MCO and Magellan will submit an Addiction Treatment Services Network Development Plan to DMAS in Fall 2016 describing its current addiction treatment services network and plan to develop a more comprehensive network by ASAM level of care in each region.
- ⇒ Each MCO and Magellan will submit an Addiction Treatment Services Network Readiness Plan to DMAS in early 2017 describing its addiction treatment services network by region and specifying which ASAM levels of care will have adequate numbers of providers and which lack specific provider types.

⇒ DMAS will compare addiction treatment services networks with the list of all addiction treatment service providers who meet each ASAM level of care in each region and are licensed by DBHDS to verify that each MCO and Magellan have developed the most comprehensive networks possible given the shortages of specific provider types in specific regions.

⇒ To the greatest extent possible, the MCOs and Magellan will aim to maintain compliance with length of stay limits, e.g., 30 day average length of stay for residential services. Should length of stay limits be exceeded, the MCO or Magellan will provide evidence to DMAS that such limits were exceeded due to the lack of availability of a level of care as identified in their SUD Network Readiness Plan.

Care Coordination

DMAS, the MCOs and Magellan will continue to work with community-based coalitions of key stakeholders in each region to enhance coordination between addiction treatment service providers, primary care, FQHCs, corrections systems, medical schools, pharmacy schools, and long-term services and supports to ensure the coordination of care for all members. Substance abuse case managers and certified recovery coaches at the provider level will provide case management and peer navigation for members receiving addiction treatment services.

The MCOs and Magellan will implement structured care coordination plans for achieving seamless transitions of care. These plans will address overall care coordination for the new addiction treatment services benefit, transitions between all addiction treatment levels of care, transitions between addiction treatment service providers, transitions between delivery systems (i.e., moving from FFS to MCO), collaboration between behavioral health and physical health systems, and collaboration between the MCOs and Magellan.

Plans for Overall Care Coordination for the Addiction Treatment Services Benefit

DMAS, in collaboration with the MCOs and Magellan, will ensure that care coordination practices will focus on each individual's unique needs in order to provide targeted, high quality care that will improve patient engagement and support long term recovery. Practices will be built on person-centered planning, principles of recovery and resiliency, and fidelity to wrap-around principles. Goals for care coordination will include improving the health and wellness of individuals with complex and special needs and integrating services around the care needs and life circumstances of individuals. Care managers will perform the full range of service coordination beginning with pre-service and concurrent authorization review through intensive case management, when required.

The model for addiction treatment services care coordination will involve assessing the whole person including physical health, mental health and substance use. Once an assessment is completed and the member's needs have been identified, appropriate referrals will be made to ensure that the member's needs are met in support of their holistic and whole-person health.

The MCOs and Magellan will utilize data from multiple sources, including utilization data, health risk assessments, state agency aid categories, demographic information, Health Department epidemiology reports, and various other sources to ensure identification of members with complex health needs, i.e., members who

require the extensive use of resources and who need help in navigating the system to facilitate appropriate delivery of care and services. The MCOs and Magellan will ensure that addiction treatment care coordination for members with complex needs helps them regain optimum health and/or improved functional capability, in the right setting and in a cost-effective manner. "High-touch" members will be assisted by connecting them with community based providers and coordinating with those providers and other entities to ensure each member's needs are met. The MCOs and Magellan will coordinate and engage in case conferences with providers to discuss each member's needs and to ensure that those needs are included in a comprehensive plan of care.

Research has shown that some women observe a decrease or cessation of their menstrual period, either directly from drugs or from lifestyle issues when using substances, and as a result erroneously believe they are infertile and that contraception is unnecessary. Further, research has shown that women, while under the influence of substances, often did not take into account the importance of contraceptive use during sexual activity. The MCOs and Magellan will be encouraged to develop special management care coordination structures to manage pregnant and post-partum populations with histories of or current use of substances. This care coordination will facilitate a healthier recovery environment with focus on family planning strategies to concurrently address improvements in maternal and child health and positive birth outcomes along with addiction treatment approaches.

In order to minimize barriers to care, the MCOs and Magellan will ensure that behavioral health professionals performing addiction treatment service assessments have telehealth capabilities. Care managers will be knowledgeable about the telehealth delivery system in Virginia and will refer members in rural and other hard to access areas to these systems in order to receive an assessment. It is expected that there will be some members who will not be able to access this evaluation through a telehealth solution or an office visit due to transportation, psychosocial, or health issues, thus the MCOs and Magellan will contract with a subset of evaluators to provide in home evaluations in order to accommodate the needs of these members.

The MCOs and Magellan will provide members access to clinical staff twenty-four hours a day, seven days a week through a toll-free number. Through such access, clinical staff will work with members to determine their needs, discuss behavioral health service options and assist them in identifying an appropriate provider. If at any time, a caller is in distress or appears to have complex needs or a complicating condition such as a physical disability, a clinical care manager will provide appropriate triage and referral.

The MCOs and Magellan will support proactive, collaborative multi-agency case planning processes for adults and youth with special needs to ensure access to appropriate community resources. Mechanisms for this collaboration may include letters of agreement and an array of actions such as the following:

- consistent communications,
- supportive written policies, procedures and processes,
- joint case reviews and treatment planning,
- regular meeting participation,
- data sharing and reporting,
- joint projects and initiatives,

- coordinating with early intervention services, and
- coordination with the adult criminal justice and juvenile justice systems.

Transitions between All Addiction Treatment Levels of Care

The MCOs and Magellan will ensure seamless transitions and information sharing between levels and settings of care. Whenever possible and clinically indicated, the MCOs and Magellan will assign each member to a specific care manager who will work with the member and providers throughout the course of treatment. This assignment practice will allow the case manager to become familiar with the unique needs of the member and ensure that all relevant information will be shared with the treating provider as the member transitions from one level of care to the next.

Additionally, all providers will be required to engage in appropriate discharge planning including coordination with the providers at the next level of care to ensure there are no gaps and that the new provider is aware of the progress and activities from the prior treatment level of care. The MCOs and Magellan will provide ongoing education to providers about these expectations and conduct chart reviews to ensure compliance and opportunities to improve quality of care.

Transitions between Addiction Treatment Services Providers

The MCOs and Magellan will build on their current care coordination models to further develop appropriate links for individuals receiving addiction treatment services to specific and qualified addiction treatment service providers. In addition to the care coordination practices described above, the MCOs and Magellan will work with members and providers to ensure smooth transitions between providers in order to avoid disruptions in care. The MCOs and Magellan will facilitate the transfer of necessary clinical information between treating practitioners to foster continuity of care and progress toward a member's recovery. Coordination of treatment approaches and integration of member and provider communication will help to keep members safe and informed of care planning options and choices.

Collaboration between Behavioral Health and Physical Health Systems

The MCOs and Magellan will inform entities including CSBs, private behavioral health providers, FQHCs, primary care physicians, emergency departments, and hospitals of the resources available to them when integrating services or developing comprehensive plans of care for members. The MCOs and Magellan will also work with these entities to develop workflows specific to operational interfaces and to streamline communication and efforts to maximize efficiencies when assisting with member access to necessary care. Virginia's electronic Health Information Exchange is piloting the sharing of PMP data with health systems and Emergency Department EHRs and will be leveraged as possible. Activities to support improved collaboration between systems will continue to be explored.

Collaboration between MCOs and Magellan for Mental Health Services

The MCOs will continue to refer and collaborate with Magellan for mental health services not specifically related to substance use disorders. Magellan case management staff will assess member needs for carved out psychiatric or psychosocial services and refer as necessary to providers. Magellan will ensure communication via medical records and other appropriate means to enable the MCOs to adequately track member progress.

Integration of Physical Health and Addiction Treatment Services

DMAS is committed to integrating physical and behavioral health care services for members to improve health outcomes and reduce costs in addiction treatment services. To fully integrate physical and behavioral health services for individuals with SUD and expand access to the full continuum of services, DMAS obtained approval from the Governor and the General Assembly to "carve in" the community-based addiction treatment services into managed care for members who are already enrolled in MCOs. These services include the following:

- Residential Treatment,
- Opioid Treatment,
- Substance Abuse Day Treatment,
- Crisis Intervention,
- Intensive Outpatient Treatment,
- Substance Abuse Case Management, and
- Peer Supports.

Since the MCOs already manage all the physical health services as well as the inpatient services, outpatient services, and medications for mental health and substance abuse, "carving in" the community-based addiction treatment services will allow them to provide members with the full continuum of addiction treatment services based on their level of need and to integrate the addiction treatment services with physical health and traditional mental health treatment services. Magellan will continue to cover these services for those Medicaid members who are enrolled in Fee-for-Service.

All activities under this demonstration will maintain focus on the primary care physician (PCP) relationship as the member's provider "health home." This strategy will promote one provider having knowledge of the member's health care needs, whether disease specific or preventive care in nature. Through contractual language, training, and program components, the MCOs and Magellan will ensure that primary care physicians are educated regarding their responsibilities.

DMAS is in the process of amending the managed care contracts and Medallion 3 Waiver to facilitate an integrated care model to support the coordination of physical health and behavioral health services, e.g., through care coordination practices identified by the SUD Core Workgroup with MCOs, providers, health systems, FQHC, and consumer representatives. This integrated model will begin with implementation of the addiction treatment services demonstration effective on April 1, 2017.

Program Integrity

DMAS requires each MCO and Magellan to be National Committee for Quality Assurance (NCQA) accredited or to attain such accreditation within 36 months of the onset of delivering care to members. Plans that are not accredited at start-up will adhere to NCQA while they are working on accreditation. NCQA requires the plan to adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the

Accreditation of MCOs. The standard categories include: Quality Management and Improvement, Standards of Utilization Management, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), Consumer Assessment of Health Care Providers and Systems (CAHPS) survey, and Standards for Credentialing and Re-credentialing. *Appendix E* provides an illustration of the DMAS process for ensuring MCO and Magellan compliance with contractual requirements.

Risk-Based Screening and Credentialing of All Newly Enrolled Providers and Revalidating Existing Providers

In accordance with NCQA Credentialing and re-credentialing requirements, the MCOs and Magellan will have the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the plan or its providers are qualified to perform addiction treatment services. The MCOs and Magellan will maintain written policies and procedures for the credentialing process that matches the credentialing and re-credentialing standards of the most recent guidelines from NCQA and in accordance with 12 VAC 5-408-170. The re-credentialing process must include the consideration of performance indicators obtained through the Quality Improvement Plan , utilization management program, grievance and appeals system, and member satisfaction surveys.

Ensuring That Addiction Treatment Services Providers Have Entered Into Contracts

MCOs and Magellan are Medicaid payers of all addiction treatment services Medicaid benefits and will ensure that all providers of addiction treatment services have entered into contracts or provider agreements.

Processes To Address Billing and Other Compliance Issues

The MCOs and Magellan will have rigorous program integrity protocols in place to safeguard against fraudulent billing. They will require their providers to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs.

Quality Reviews of Addiction Treatment Services Providers

DMAS will require the MCOs and Magellan to perform an annual review on all providers to assure that the health care professionals under contract with the provider are qualified to perform addiction treatment services and that services are being provided in accordance with contract, ASAM and waiver requirements. The MCOs and Magellan will have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. They will be required to report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers) including program integrity-related and adverse actions.

Benefit Management

The MCOs and Magellan will delineate utilization management and quality review processes in their provider contracts. Minimum requirements are outlined in Table 6 below:

Process	Description
Standardized Benefit Structure	Use of standardized benefit structure that defines service levels and supports placement using American Society of Addictions Medicine levels of care.
Unified Model of Care	Addiction treatment services benefits will be administered by all MCOs and Magellan using a unified model of care that is defined by the use of standardized unit values, reimbursement codes and a minimum reimbursement value for each service level.
Uniform Clinical Operations	Standardized service review formats will be used by the MCOs and Magellan to ensure that clinical operation processes are uniform and designed to collect information in line with MHPAEA requirements to ensure appropriate placement, allow for quality management and facilitate opportunities for integrated care and coordination of service delivery options for individuals.
Service Review Requirements	SUD ASAM Levels 2.1-4.0 will be subject to utilization management requirements including service review requirements to facilitate initiation of services with quality oversight structures in place as specified in the CMS SMD # 15-003. ❖ Upon admission to Intensive Outpatient or Partial Hospitalization services a service provider will be required to conduct an assessment of need and submit clinical information to either an MCO or Magellan for their review. ❖ Prior to admission to Residential Treatment and Inpatient, service providers will be required to complete a preadmission assessment of the individuals clinical needs and submit the clinical information to either an MCO or Magellan for their review. ❖ All residential levels of care will require an ASAM multidimensional assessment to be reviewed by the MCO or Magellan as part of the utilization management structure for accessing residential services in both IMD and non-IMD residential service settings. ❖ Each service review will be provided to assess service needs, coordination needs and to ensure appropriate placement into an effective level of care based on the individual's needs as demonstrated in the ASAM multi-dimensional assessment tool.
Quality Reviews	Targeted post-payment quality reviews to ensure fidelity with ASAM service models and assess for the use of evidence based delivery services.
MAT Management	Medication Assisted Treatment services will be managed using a multifaceted approach that includes pharmacy and laboratory management and data mining to provide surveillance of service delivery. This approach will ensure counseling, physician services, pharmacy and labs are administered in accordance with ASAM guidelines for MAT while allowing immediate access to withdrawal management and treatment. MAT will also be managed using standardized approaches to provider credentialing requirements that enforce evidence-based service delivery and enable more effective management of the Office Based Opioid Treatment service. This will ensure pharmacy management and integrated services are delivered and quality assurances are met in accordance with newly defined credentialing standards for buprenorphine-waivered physicians and other providers who administer MAT services in office settings.
Prescription Monitoring	Billing and pharmacy system edits will be implemented to ensure appropriate access to methadone, buprenorphine, extended-release injectable naltrexone, and other evidence-based medications for MAT while increasing surveillance of other pharmacy prescribing behaviors to ensure alignment with the CDC Opioid Prescribing Guidelines. As part of the Medication Assisted Treatment administration multiple drug classes will receive additional utilization management controls to ensure effective treatment and a safe recovery environment is maintained for the individuals in recovery. Current efforts are focused on pharmacy management and edits to the DMAS preferred drug list to limit opiate and benzodiazepine utilization by individuals engaged in Medication Assisted Treatment. Additional utilization management controls are being discussed to ensure tighter network controls are in place to manage physician prescribing activity on targeted drug classes and to enforce network alignment for selected pharmacy benefit management. In addition, the MCOs are implementing a Lock-in program that allows them to monitor members who are prescribed buprenorphine by only allowing them to obtain controlled substances from one pharmacy and one physician.

Table 7: Components of Addiction Treatment Services Benefit Management

The MCOs and Magellan will implement a standardized benefit management and reimbursement structure to enhance aggressive network recruitment efforts. The MCOs and Magellan will conduct initial and concurrent authorizations using the criteria and benefit limits delineated in the addiction treatment services reimbursement structure (see *Appendix B).*

Compliance with Mental Health Parity and Addiction Equity Act

The MCOs and Magellan will ensure compliance with the Mental Health Parity and Addiction Equity Act. Criteria for requiring prior authorization will be applied consistently across addiction treatment services, behavioral health services, and physical health services.

The SUD utilization and quality management structures will be required to ensure that individualized recovery and resiliency-oriented services are delivered according to the ASAM care model. Both the MCOs and Magellan will be encouraged to develop a quality management program that focuses on driving and rewarding service delivery using ASAM standards; measuring, assessing, and continually improving member outcomes; and ensuring the use of evidence-based practices, especially those for community-based services.

Community Integration

Under this demonstration, MCOs and Magellan will require providers to ensure, to the greatest extent possible, that addiction treatment services are based upon identified specific member needs and documented and justified in a person-centered service plan.

Person-Centered Planning

The MCOs and Magellan will ensure that requirements for person-centered planning are incorporated into all addiction treatment service planning and service delivery efforts. Addiction treatment service planning and delivery will be based upon a person-centered assessment designed to help determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. Service planning will address each individual's vision of a good life, individual talents and contributions and "what's working/what's not working" in the following life areas:

- Home,
- Community and interests,
- Relationships,
- Work and alternates to work,
- Learning and other pursuits,
- Money,
- Transportation and travel, and
- Health and safety.

The MCOs and Magellan will implement strategies to collect member experiences, e.g., surveys and complaint/grievance processes. Results will be reviewed and analyzed on a continuous basis as a measure of

member satisfaction. Low or inadequate scores will be analyzed, opportunities for improvement identified and interventions such as changes in workflows and/or processes implemented to improve member satisfaction.

Cultural and Linguistic Competency

The MCOs and Magellan will ensure that providers deliver services in a manner that demonstrates cultural and linguistic competency. Members will be able to select programs and providers within those programs that meet their needs for self-determination, recovery, community integration, and cultural competency.

To ensure that programs and services meet the cultural and linguistic needs of members, the MCOs and Magellan will utilize sources such as census data and enrollment files to identify member language, race and ethnicity when possible to determine additional languages for written materials, compatibility with practitioner networks, cultural and linguistic needs of members and other potential healthcare needs that might be associated with cultural beliefs and healthcare behaviors.

Peer Supports

In the 2016 session of the General Assembly DBHDS proposed a bill to create a state certification for substance abuse peer providers. This bill will become law on July 1, 2016. Under this demonstration, peer support services will be made available to Medicaid members receiving addiction treatment services at all levels of care effective on July 1, 2017.

Peer support resources will be an integral component of community integration. DBHDS will establish a certification and define the scope of practice for "Certified Peer Recovery Specialists." The SUD Core Workgroup reviewed the proposed scope of practice which is included as *Appendix F.*

Strategies to Address Prescription Drug Abuse

Across the Commonwealth, 986 people died due to fatal drug overdoses in 2014. Nearly 80% of these deaths involved prescription opioids or heroin. The Virginia Department of Health reported a 38% increase in deaths from prescription opioid and heroin overdoses between 2012 and 2014 with fatal drug overdoses occurring in counties and cities across Virginia (see Figure 5). According to a recent study of the Centers for Disease Control and Prevention (CDC), "Payments for Opioids Shifted Substantially to Public and Private Insurers While Consumer Spending Declined, 1999-2012," released in *Health Affairs*, changes in financing and cost of opioid pain relievers coincide with the large increase in overdose deaths associated with these drugs. The study documents declining opioid drug unit costs, and the shifting of those costs from the consumer to insurers during these years. The study highlights the need to scale up effective programs which include opioid prescribing guidelines and strategies to equip health care providers with data, tools, and guidance so they can make informed treatment decisions.

The Governor's Task Force on Prescription Drug and Heroin Abuse in Virginia proposed numerous recommendations to the Administration that were designed to strengthen the Prescription Monitoring Program (PMP) and to support providers in proper prescribing and dispensing practices. In both the 2015 and 2016 General Assembly sessions, bipartisan legislation was introduced to align to these and other recommendations of the Task Force.

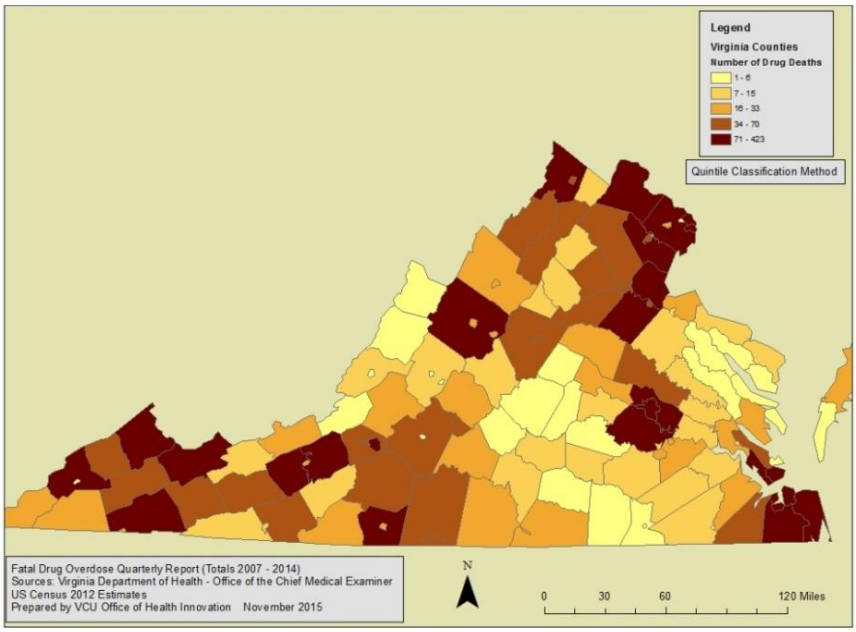


Figure 5: Number of Fatal Drug Overdoses in VA Counties and Cities, 2007-2014

In the 2015 session, legislation was passed to include pharmacists in Virginia's mandatory PMP registration and removed the administrative requirement that PMP registration be done upon licensure renewal. Recognizing that diversion of prescribed opiates is a major contributor to the overdose epidemic, legislation to require hospice settings to notify pharmacies of a patient's death was also passed. Additionally, an existing regional pilot that made naloxone available to friends and family members, i.e., "lay rescuers," was expanded statewide by the General Assembly; the same piece of legislation created an avenue to allow pharmacists to dispense naloxone under proper protocol.

In the 2016 General Assembly session, several bills were passed that focused specifically on the utilization of the PMP for both prescribers and dispensers. Virginia will now require that providers check the PMP for every opioid prescription written for more than 14 days. Furthermore, the PMP Director can now send unsolicited reports on egregious provider behavior for internal review, a practice that is already codified for suspected doctor-shopping behavior by patients. Another piece of legislation reduced reporting time for dispensers from 7 days to 24 hours to help flag and curb doctor-shopping behavior, allowed for clinical consultation with pharmacists regarding patient history, and clarified that a copy of a PMP patient report could be included in a patient's medical history. Finally, the General Assembly passed a bill that mandates completion of 2 hours of Continuing Medical Education (CME) for identified prescribers (based on prescribing history data) on topics related to pain management, responsible prescribing, and the diagnosis and management of addiction. Another bill grants access to the PMP to Medicaid MCOs to identify members with behaviors suggesting opioid abuse or misuse. These bills will become law on July 1, 2016.

The SUD Core Workgroup convened by DMAS developed comprehensive strategies to address prescription drug abuse at the state, MCO, patient, pharmacy and provider level that will be implemented across Medicaid the MCOs and Magellan and will complement this robust PMP legislation. These strategies include integrating *CDC Guidelines for Prescribing Opioids for Chronic Pain* into the DMAS FFS Preferred Drug List (PDL) and into

the MCO formularies, implementing an innovative Lock-In program to identify members with or at risk of prescription drug abuse and opioid use disorder and refer them to addiction treatment services, and introducing claims edits for concurrent opioid and benzodiazepine prescriptions.

Integrating CDC Opioid Prescribing Guidelines into DMAS FFS PDL and MCO Formularies

In accordance with changes approved by the DMAS Pharmaceuticals and Therapeutics Committee in April 2016, the MCOs and Magellan will implement requirements for prescribing short and long-acting narcotics to align Medicaid prescription drug coverage with the *CDC Guidelines for Prescribing Opioids for Chronic Pain*. These requirements are described below.

Short and Long Acting Narcotics

- Prescriber must calculate the morphine milligram equivalents (MME) for prescribed drug
  - If MME is 51-90 per day – prescriber must offer naloxone and overdose prevention education.
  - If MME is > 90 per day – prescriber must give member a prescription for naloxone, provider overdose prevention education and consider a consultation with a pain specialist.
  - A link to a MME calculator and to Virginia's PMP will be included.
- Prescriber must document what other non-pharmacological alternatives the patient has tried including physical therapy, weight loss, aerobic exercises, aquatic exercises, resistance exercises, arthrocentesis, intraarticular glucocorticoid injection, subacromial corticosteroid injection, and psychological therapies such as cognitive behavioral therapy.
- Prescriber must document what other non-opioid pharmacological therapies have been tried including NSAIDs, muscle relaxants, anti-convulsants, Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs).
- Prescriber must attest that the PMP has been checked for all new prescriptions and they have discussed with the patient any findings and the risks of using other central nervous depressants such as benzodiazepines, alcohol, other sedatives, illicit drugs such as heroin, or other opioids.
- The service authorization form asks "Does this patient exhibit signs of opioid use disorder?" and requires the prescriber to indicate if the patient has a history of addiction to the requested drug, frequent request for odd quantities, requests for short-term or PRN use of long-acting narcotics, frequent requests for early refills, and frequent reports of lost or stolen tablets.
- The service authorization form requires the physician to attest that a realistic treatment plan with goals to address the benefits and harm of opioid therapy has been established with the patient. The prescriber must address all five CDC recommendations for this treatment plan:
  - Established expected outcome and improvement in both pain relief and function or just pain relief as well as limitations (i.e., function may improve yet pain persist OR pain may never be totally eliminated).
  - Established goals for monitoring progress toward patient-centered functional goals e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities, etc.
  - Goals for pain and function, how opioid therapy will be evaluated for effectiveness & the potential need to discontinue if not effective.
  - Emphasize Serious Adverse Effects of Opioids (including fatal respiratory depression & opioid use disorder, OR alter the ability to safely operate a vehicle).
  - Emphasize Serious Common Side Effects of Opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)
- Prescriber agrees to evaluate and reassess the benefits and harm of continued opioid therapy with the patient every 3 months or more frequently if dose changes.

- A link to a prescriber/patient opioid use contract in the event the prescriber does not have a standardized form which he/she currently uses is included on the service authorization form.
- A link to the CDC Guidelines for Prescribing Opioids is included on the service authorization form.

Short Acting Narcotics

- Quantity limits will be placed on all short acting narcotics based on 120 MME/day x 10 day supply. Anything above these quantity limits will trigger a service authorization.
- The exception to 120 MME/day will be any combination narcotic that contains acetaminophen. The quantity limit will be based on the maximum 4 grams/day of acetaminophen.

Long Acting Narcotics

- Requirement of a urine drug test at least annually
- Trial and failure of a short-acting opioid for at least one week

Implementation of an Innovative Lock-In Program by MCOs

Under this demonstration the MCOs will continue implementation of the existing innovative Patient Utilization Management and Safety (PUMS) Program to identify members with or at risk of prescription drug abuse or opioid use disorder and connect them with treatment. The program will ensure that members are accessing and utilizing prescription drugs appropriately and are provided care coordination and referrals to addiction treatment services when they exhibit behaviors consistent with prescription drug abuse and/or an opioid use disorder.

Members will be placed in the PUMS program for 12 months when either:

1) the MCO's utilization review of the member's past 12 months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or

2) medical providers or social service agencies provide direct referrals to DMAS or the MCO.

Criteria to evaluate a member for possible placement in the PUMS program are outlined below in Table 7:

Descriptor	Criteria
Buprenorphine Containing Product	Therapy in the past 30 days (AUTOMATIC LOCK-IN)
High Average Daily Dose of Prescription Opioid	Greater than 120 morphine milligram equivalents per day over the past 90 days
Overutilization	Filling of greater than 7 claims for any controlled substance in past 60 days
Doctor or Pharmacy Shopping	Greater than 3 prescriptions OR greater than 3 pharmacies writing/filling claims for any controlled substance in the past 60 days
Use with a History of Dependence	Any use of a controlled substance in the past 60 days with at least 3 occurrences of a medical claim for controlled Substance Abuse or Dependence in the past 365 days

Use with a History of Poisoning/Overdose	Any use of a controlled substance in the past 60 days with at least 3 occurrences of a medical claim for controlled Substance Abuse or Dependence in the past 365 days
"Frequent Flyer"	Greater than 3 Emergency Department visits in the last 60 days
Poly-Pharmacy	Greater than 9 unique prescriptions in a 34 day period written by greater than 3 physicians OR filled by greater than 3 pharmacies

Table 8: Prescription Utilization Management Safety Program Evaluation Criteria

The MCOs will apply the lock-in by limiting a member to a single pharmacy, a single primary care provider (PCP), or a single controlled substances prescriber. At the end of the 12 month period, the member will be re-evaluated to determine if the member continues to display behavior or patterns that indicate the member should remain in the PUMS Program.

Strategies to ensure the same protections for members in Fee-for-Service will be identified prior to implementation of this demonstration, for example through Magellan's coordination with the Client Medical Management program.

Introducing Claims Edits for Concurrent Opioid and Benzodiazepine Prescriptions

DMAS and the MCOs are exploring implementation of point of service edits for managing opioid and benzodiazepine prescriptions and for which an override would require prescriber involvement. Identified edits will be implemented under the addiction treatment services demonstration. Potential edits include:

1) initiation of concurrent opioid and benzodiazepine prescriptions; or
2) any additional oral benzodiazepine prescriptions for patients currently on benzodiazepines and opioids; or
3) any additional opioid prescriptions for patients currently on benzodiazepines and opioids; or
4) benzodiazepine prescription for patients currently being treated with an oral buprenorphine containing drug.

Strategies to Address Opioid Use Disorder

DMAS and DBHDS will leverage this demonstration to support the U.S. Department of Health and Human Services priority areas of promoting opioid prescribing practices, expanding use and distribution of naloxone, and expanding MAT to reduce opioid use disorders and overdose. This demonstration will implement the following specific strategies:

1) promoting the CDC Guidelines for Prescribing Opioids for Chronic Pain to providers across the Commonwealth;
2) encouraging providers to co-prescribe naloxone with opioids and widely disseminating naloxone through Project REVIVE!, the state's opioid overdose reversal program;
3) increasing MAT coverage and promoting evidence-based best practices through standardized service authorization forms;
4) implementing a robust benefit package to incentivize providers to offer MAT for opioid addiction;

5) delivering a Comprehensive MAT Provider Education and Training Campaign statewide; and
6) partnering with the Board of Medicine to develop guidelines for buprenorphine providers.

Promoting CDC Guidelines for Prescribing Opioids for Chronic Pain

Virginia is actively addressing the opioid overdose crisis. In May 2016, Virginia's Secretary for Health and Human Services sent a letter (see *Appendix G*) to all prescribers in the Commonwealth encouraging them to follow the recommendations in the *CDC Opioid Prescribing Guidelines* and announcing the requirement, effective July 1, 2016, that all prescribers must check the PMP for most prescriptions lasting more than fourteen days. In addition, DMAS and the MCOs are aligning Medicaid prescription drug coverage with the *CDC Opioid Prescribing Guidelines* as described above.

Expanding Access to Naloxone Statewide

DMAS and the MCOs all cover intranasal naloxone without a Prior Authorization and will encourage providers and pharmacies to carry naloxone. In addition, DMAS and the MCOs will require prescribers to offer naloxone to any patient taking greater than 50 morphine milligram equivalents of a prescription drug per day and require prescribers to give prescriptions for naloxone to any members taking greater than 90 morphine milligram equivalents per day.

Virginia's efforts to widely disseminate naloxone were bolstered by legislation passed by the Virginia General Assembly in 2015 that authorizes a pharmacist to dispense naloxone pursuant to an oral, written or standing order issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. The law also allows a person to possess and administer naloxone to another person who is believed to be experiencing or about to experience a life-threatening opiate overdose. Additionally, law-enforcement officers and firefighters who have completed a training program may also possess and administer naloxone.

REVIVE! is the Opioid Overdose and naloxone Education (ONE) program for the Commonwealth of Virginia. REVIVE! is a statewide program that distributes naloxone kits and provides training across the Commonwealth to health care professionals, law enforcement officers, firefighters, advocates, and others on how to recognize and respond to an opioid overdose emergency with the administration of naloxone. REVIVE! is a collaborative effort led by DBHDS working collaboratively with the Virginia Department of Health, the Virginia Department of Health Professions, recovery community organizations, OneCare of Southwest Virginia, the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), and other stakeholders.

Increasing MAT Coverage and Promoting Evidence-Based Best Practices

MCOs and DMAS currently cover an array of medications approved for MAT for opioid use disorder and alcohol use disorder. Under the SUD waiver, access to these medications will be expanded by minimizing prior authorizations (see Table 8 below).

Medication	Service Authorization Required	Availability (Opioid Treatment Program (OPT), Pharmacy (Rx), Physician Administered Drug(PAD))
Buprenorphine Containing Drugs	yes	OPT, Rx, PAD

Methadone	yes	OPT, Rx, PAD
Naltrexone Tablets	No	OPT, Rx, PAD
Naltrexone Long-Acting Injection (Vivitrol®)	No	OPT, PAD
Disulfiram	No	OPT, Rx, PAD
Acamprosate	No	OPT, Rx, PAD

Table 9: MAT Medications and Availability in Virginia Medicaid's FFS Program

Clinicians have expressed that they are more likely to prescribe buprenorphine containing drugs to Medicaid members if there are fewer administrative barriers and they can utilize standardized service authorization request forms for DMAS FFS members and all Medicaid health plan members regardless of the MCO. To promote evidence-based best practices, the MCOs and Magellan will all use uniform service authorization request forms for buprenorphine/naloxone (Suboxone®) or buprenorphine (Subutex®) initiation and maintenance. Standardized forms were created by the SUD Core Workgroup (see *Appendix H and Appendix I*). These forms are designed to increase access to a life-saving medication for opioid addiction, ensure that Virginia's Medicaid members receive evidence-based best practices for MAT such as counseling and urine drug screening, avoid non evidence-based restrictions such as daily or lifetime limits, and minimize the risk of diversion and abuse. Eliminating the service authorization requirement for Vivitrol® (Extended Release Naltrexone) removes another barrier to best practice (i.e., members are no longer required to fail oral naltrexone before Vivitrol® can be used).

MAT Benefit Package and Incentives for Clinicians to Provide MAT

Under the addiction treatment services demonstration, MCOs and Magellan will administer a robust MAT benefit package for opioid use disorder that supports comprehensive, evidence-based treatment at Opioid Treatment Programs and in Office-Based Opioid Treatment settings such as FQHCs, primary care clinics, and psychiatry practices. The MAT reimbursement structure is outlined in *Appendix B*.

Recognizing that counseling and psychosocial supports, i.e., case management and care coordination must be provided alongside medication to ensure the best outcomes for patients, DMAS will implement financial incentives to provide sustainable Medicaid reimbursement for such supports. These services and fiscal incentives are outlined in Table 9 below:

Opioid Treatment	
Description	Components of Psychosocial Treatment for Opioid Use Disorder include at a minimum: • Assessment of psychosocial needs • Supportive individual and/or group counseling • Linkages to existing family support systems • Referrals to community-based services
Provider Type	Provided by LCSWs, LPCs, or licensed psychologists knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders. They receive supervision appropriate to their level of training and experience.
Reimbursement	Can only be billed by DBHDS licensed providers.
Incentive	400% rate increase
Substance Abuse Case Management	
Description	Includes medical monitoring and coordination of on-site and off-site treatment services, provided as needed. Case managers will also assure the provision of, or referral to, educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care, and other adjunct services, as needed.
Provider Type	Provided by LCSWs, LPCs, or CSACs
Reimbursement	Can be only billed by DBHDS licensed providers.
Incentive	50% rate increase

Substance Abuse Care Coordination	
Description	Integrates behavioral health into primary care and specialty care medical settings through co-location. Links patients with opioid addiction with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs. Tracks and supports patients when they obtain medical, behavioral health, or social services outside the practice. Follow up with patients within a few days of an emergency room visit or hospital discharge for opioid overdose or any other reason. Communicates test results and care plans to patients and families.
Provider Type	Can only be provided by LCSW, LPC, Psychiatric NP, Mental Health RN, or CSAC who is providing integrated care coordination in the office of the treating physician who is prescribing or buprenorphine.
Reimbursement	• This code must be billed with Opioid Use Disorder as the primary diagnosis. • Must be billed by buprenorphine-waivered physician who is prescribing buprenorphine and providing the integrated care coordination on-site at his or her practice.
Incentive	New reimbursed service

Table 10: MAT Psychosocial Supports

Comprehensive MAT Provider Education and Training

DMAS is partnering with the Virginia Department of Health to develop a comprehensive MAT training curriculum focused on providing buprenorphine in office-based opioid treatment settings. In addition, DBHDS and DMAS will develop reference materials on how to bill for and obtain reimbursement for MAT (methadone and buprenorphine). The training will include three tracks: 1) physicians and other providers; 2) counselors, social workers, care coordinators, case managers, and recovery coaches; and 3) clinic administrators on models for the delivery of and billing for addiction treatment services incorporating MAT with a focus on buprenorphine. Figure 6 below outlines the proposed training plan.

Phase 1: "Train the Trainers" and Training at Major Provider Conferences July - November 2016

- VDH and contractor will offer special "train the trainer" events to train local physicians, behavioral health providers, and administrators in the new curricula so they are prepared to lead the trainings in their regions in early 2017.
- VDH, DMAS, and contractor will partner with major provider organizations to offer 4-hour CME seminars on MAT aligned with their annual meetings including the PSV and MSV Annual Meetings in October in Roanoke and the Virginia Community Healthcare Association Annual Meeting in October in Metro Richmond. These CME seminars will include an introduction with an overview of the delivery model and business case for addiction treatment followed by break-out sessions with three separate tracks for: 1) physicians/providers - 4 hours of MAT training to help physicians obtain suboxone waivers; 2) counselors/social workers/recovery coaches – 4 hours of training on group therapy model and care coordination for suboxone; 3) clinic administrators and staff – operationalizing treatment model and billing for MAT.
- The Virginia Commonwealth University research team will disseminate surveys at each training to assess provider satisfaction with the trainings and provide recommendations of any opportunities for improving the curricula.

Phase 2: Train the Providers, January - March 2017

- Trainers trained by VDH and the contractor in the fall will lead trainings in each of the state's major regions including Far Southwest, Roanoke/Allegheny, Halifax/Lynchburg, Charlottesville/Piedmont, Central Virginia, Tidewater, and Northern Virginia/Winchester
- The Virginia Commonwealth University research team will track how many providers are trained at each training and will collect surveys that assess provider satisfaction with the trainings and intention to provide MAT after the training. VCU researchers will follow-up with physicians and providers after the training to evaluate how many are actually offering MAT and any barriers to MAT implementation.

Phase 3: Go Live and Engage Trainer Support Networks, April 2017- April 2018

- VDH will provide ongoing clinical support to physicians and clinic staff who are implementing MAT programs and providing buprenorphine in office-based opioid treatment settings. DMAS and DBHDS will provide ongoing support and guidance on reimbursement to providers.
- DMAS will work with Magellan to develop a Virginia MAT support network for new providers with a hotline to call about difficult patient challenges, regulatory questions, etc.
- The trainers in each region will become regional champions who receive ongoing financial support to serve as a mentor by providing advice to new MAT providers in their region about difficult patient challenges, etc. These regional champions could even also hold weekly or monthly meetings or webinars that serve as case conferences where new MAT providers could bring challenging patient cases and receive advice.

Figure 6: MAT Provider Training Plan

Guidelines for Buprenorphine Providers

The General Assembly during the 2016 session passed legislation that clarified that buprenorphine and other FDA-approved opioid replacement therapy providers are not subject to the same regulatory environment as methadone providers in Virginia. The Virginia Board of Medicine is convening a workgroup to develop guidance on clinical best practices for buprenorphine providers. These guidelines will include evidence-based best practices such as ensuring that counseling and psychosocial supports are offered alongside the buprenorphine medication and requiring that buprenorphine providers check the PMP and random urine drug screens to decrease the risks of diversion and continued substance misuse and abuse. This workgroup includes representatives from DMAS, VDH and DBHDS as well as and the MCOs, who will ensure that these best practices are adopted by DMAS, the MCOs, and Magellan and incorporated into the design and implementation of the MAT benefit.

Services for Adolescents and Youth with a SUD

DMAS will ensure that benefits are covered, services are available, and access is timely for youth and adolescents with a SUD as required under the EPSDT benefit. Care coordination efforts will be dynamic and include methods to ensure adolescent clinical issues are assessed within the context of the ASAM adolescent placement criteria. The specific focus on distinct care models for adolescents is not necessary in the ASAM model since the criteria account for unique adolescent treatment needs.

At a minimum, assessment and services for adolescents will follow the ASAM adolescent treatment criteria. In addition, the state will identify recovery services through other service systems that are geared towards adolescents, such as those described in the January 26, 2015 CMS Informational Bulletin "Coverage for Behavioral Health Services for Youth with Substance Use Disorder."

DMAS is also exploring adding a family peer support service under the new peer support service that could support adolescents and youth with a SUD. This service could be incorporated into high fidelity wrap services and other evidence-based best practices that DMAS already supports for adolescents and youth with Serious Emotional Disturbance and/or a SUD.

Reporting of Quality Measures

Collection of Quality Measures

DMAS will collect reliable and valid data from the MCOs and Magellan to enable reporting of the SUD quality measures listed in Table 10 below. These include relevant measures from the Medicaid Adult, and Children's Core Sets for individuals with SUD as well as the Pharmacy Quality Alliance opioid performance measures as specified in the CMS SMD Letter # 15-003. Use of these quality measures in program evaluation is discussed in the Evaluation section of this document.

Source	Measure	Collection Mechanism
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/encounter data
NQF # 1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	Electronic clinical data/clinical paper chart review
NQF # 2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims/encounter data
NQF #0648 (modified)	Timely Transmission of Transition Record	Electronic clinical data/clinical paper chart review
PQA	Use of Opioids at High Dosage in Persons Without Cancer (PQA)	Claims/encounter data
PQA	Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)	Claims/encounter data
PQA	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (PQA)	Claims/encounter data

Table 11: SUD Quality Measures

The MCOs and Magellan will collect data through multiple mechanisms, including automated reports from data systems, QI core indicator reports, clinical record audits, provider site visits, and complaints and grievances, etc. Data will be collected from internal sources such as from claims, demographics, pharmacy and lab results, and electronic medical records. Data quality checks will be built into all processes that touch data including data integrity and completeness checks as data are loaded and standardized. Quality checks used to verify data integrity might include comparisons against expected values, domain analysis, and comparisons to standard code sets/values. For reviewing data completeness, quality checks will assess whether all data that came into the system was processed.

Quality Improvement Process

The MCOs and Magellan will leverage, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes, and performance measure data systems to ensure continuous quality improvement of addiction treatment services. They will use the results of their performance on the SUD quality measures to improve quality under DMAS supervision and monitoring. Quality improvement processes will include both rapid cycle quality improvement as well as larger system improvements.

At a minimum, quality improvement processes will include the following:

- Monitoring system-wide issues and performance metrics,
- Identifying opportunities for improvement,
- Determining the root cause,
- Exploring alternatives and developing/approving a plan of action, and
- Activating the plan, measuring the results, evaluating effectiveness of actions, and modifying the approach as needed.

Evaluating Care Transitions

The MCOs and Magellan will implement procedures for evaluating successful care transitions between SUD levels of care as well as linkages with primary care upon discharge. Evaluation of transitions and linkages may be captured via various established activities and processes including the following:

- Collaboration with providers including the setting of expectations for successful transition planning,
- Provider education and training,
- Treatment record reviews to assess coordination with the primary care physician and referring provider(s), as well as discharge planning to appropriate providers,
- Care management and medical necessity review processes, e.g.,
    - Monitoring for appropriate transition of care and avoidance of gaps in service provision.
    - Provider outreach calls to assist in effective transition planning.

Quality Dashboards

DMAS will require the MCOs and Magellan to provide quarterly quality dashboards with the following data:

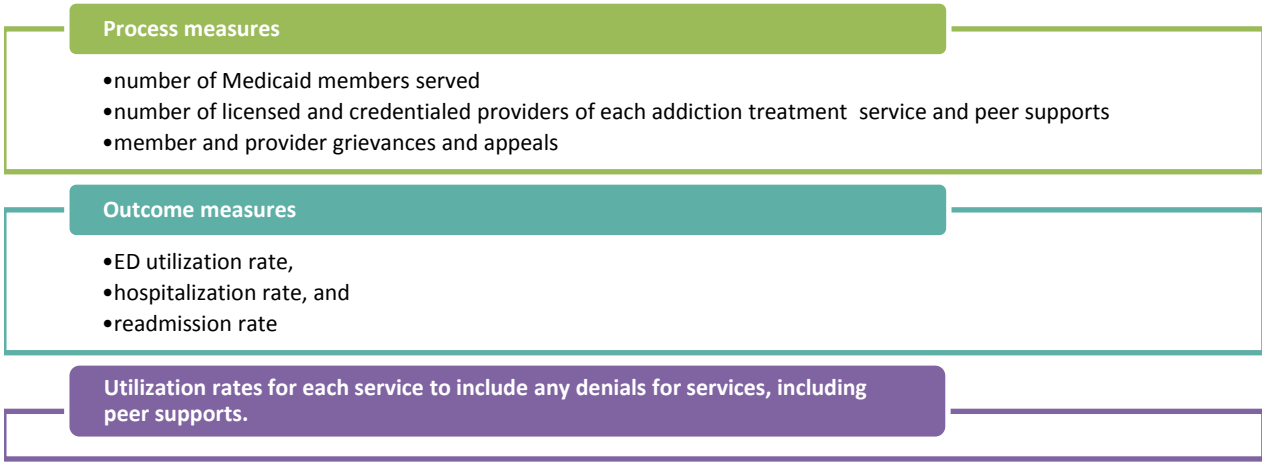


Figure 7: Quarterly Quality Dashboards

Collaboration with Single State Substance Use Disorder Authority

DMAS maintains a close working relationship the Department of Behavioral Health and Developmental Services and has collaborated with the department on all aspects of the design and implementation of the comprehensive Medicaid addiction treatment services benefit and the development of this demonstration. A formal Memorandum of Understanding between the agencies enables the sharing of data, coordination of funding, and alignment of policies and practices.

In addition, DMAS has partnered with additional state agencies including the Department of Health and the Department of Health Professions in the development of this demonstration, most specifically to align

provider qualifications and requirements and to develop the MAT provider education and training. Through the SUD Core Workgroup, DMAS has collaborated with relevant local and state agencies to ensure that they are positioned to respond appropriately to the implementation of this demonstration. Additional coordination efforts will be completed as part of readiness and training initiatives to ensure that state partners are positioned to support the delivery of addiction treatment services.

Evaluation

An independent evaluation by academic researchers at Virginia Commonwealth University (VCU) will evaluate if the delivery system transformation (i.e., the "carving in" of community-based addiction treatment services into Managed Care) and services delivered through this demonstration are effective in improving health outcomes and decreasing health care costs and utilization. The researchers will specifically assess the impact of providing the full continuum of addiction treatment services, especially residential treatment, on Emergency Department utilization, inpatient hospital utilization, and readmission rates to the same level of care or higher. For a complete description of the waiver evaluation plan, see *Appendix J.*

The VCU researchers will produce the required mid-point evaluation half way through demonstration and final evaluation at the end of demonstration. In addition, they will provide rapid cycle quality improvement data on implementation of the addiction treatment services benefit and on effectiveness of intensive MAT provider education, recruitment, and training in increasing the number of physicians providing MAT.

The evaluation is designed to demonstrate achievement of Virginia's goals, objectives, and metrics for the demonstration. Thus, the specific aims of the evaluation, which align with the demonstration's goals and objectives, are:

1. How does the demonstration affect clinician addiction treatment services training and addiction treatment services provision?
    a) To what extent are efforts to prepare and train health care clinicians successful in getting them to appropriately provide addiction treatment services benefits?
    b) How do the new addiction treatment services benefit and waiver affect the number and type of health care clinicians providing addiction treatment services to Medicaid members with SUD?
2. How does the demonstration affect members' access to and utilization of addiction treatment services?
    a) To what extent do the new SUD benefit and waiver increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering addiction treatment services to Medicaid members?
    b) How do the new addiction treatment services benefit and waiver affect the type and quantity of addiction treatment services used by Medicaid members with SUD?
3. How does the demonstration affect patient outcomes and quality of care?
    a) What is the impact of the availability of substance abuse residential treatment on emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for addiction treatment services? (e.g. inpatient admissions, community-based high intensity residential, and community-based low intensity residential).

b) Are there spillover effects of the new addiction treatment services benefit on utilization and costs for other physical and behavioral health care services, such as emergency department visits, inpatient admissions, and readmissions for non-addiction treatment related services?
c) What is the impact of the new addiction treatment services benefit on fatal and nonfatal drug overdoses among Medicaid members?
d) What is the impact of the "carve-in" of addiction treatment services benefits into managed care plans on health care utilization and the coordination of care with other behavioral and physical health problems?

4. How does the addiction treatment services demonstration affect member costs, particularly costs associated with emergency department visits, inpatient stays, and inpatient readmissions?
5. How is the addiction treatment services demonstration related to broader efforts in local communities to address SUD, especially the surge in opioid addiction?
   a) How are addiction treatment services clinicians working with other community organizations (governmental, educational, law enforcement, social service) to help people with SUD?
   b) What evidence is there that these "social determinants" are influencing use of addiction treatment services as well as outcomes, e.g. arrest rates, school attendance and performance, employment?

Budget Neutrality

DMAS assumes that if the waiver services, i.e., addiction treatment services in residential facilities with more than 16 beds, were available currently, 150 pregnant women and 820 other low income adults would use these services.

For pregnant women, DMAS assumes two tracks of care,

1. average 10 days of higher intensity care (ASAM 3.3 to 3.7) followed by 75 days of low intensity residential care (ASAM 3.1), or
2. 75 days of low intensity residential care.

All other covered adults are assumed to fall into three tracks of care:

1. just 5 days of higher intensity care,
2. just 25 days of low intensity residential care, or
3. 5 days of higher intensity residential care followed by 25 days of low intensity residential care.

All covered members are expected to continue substance use treatment using non-waiver services such as partial hospitalization, intensive outpatient, medication assistance treatment (MAT) and peer supports.

With the waiver, high intensity residential care (ASAM 3.7) includes some higher cost beds in psychiatric hospitals, but mostly through residential treatment centers. The cost of waiver services is assumed to be higher for pregnant women ($16,000) than for other adults ($5000) as pregnant women are expected to use the waiver services for a longer time per treatment episode and because they are expected to use more of the higher intensity treatment.

DMAS intends to implement the waiver April 1, 2017. The need for substance use services is growing and is expected to continue to grow through the April 1, 2017 start date. DMAS assumes a 10% year growth until the start date and then a slowing of the growth rate in the future. Based on prior experiences in managed care rate setting, DMAS expects the claims payment lag will reduce the expenditures the first year with rate and utilization increases projected to go into effect by State Fiscal Year 2018.

Virginia meets a high bar with addiction treatment services. Costs for the waiver with the expanded bed capacity are expected to be the same or lower than the benefit costs without the additional bed capacity. Implementation of a standardized ASAM treatment model is expected to result in the same utilization and cost per member. With Waiver costs are hypothetical/pass through costs. Consequently, DMAS has calculated that the With Waiver Per Member Per Month (PMPM) will equal Without Waiver PMPM (see Appendix K).

Appendix

Appendix A: Addiction Treatment Services Review Request Form

Appendix B: Addiction Treatment Services Reimbursement Structure

Appendix C: Timeline for Draft and Final SUD Amendments to State Plan, Regulations, and Provider Manuals

Appendix D: Crosswalk ASAM Provider Requirements and Virginia Licensing Requirements

Appendix E: Contract Compliance Enforcement

Appendix F: Draft Scope of Practice for Certified Peer Recovery Specialists

Appendix G: HHR Secretary Letter re. Guideline for Prescribing Opioids for Chronic Pain

Appendix H: Uniform PA Request Form for Buprenorphine/Naloxone or Buprenorphine Initiation

Appendix I: Uniform PA Request Form for Buprenorphine/Naloxone or Buprenorphine Maintenance

Appendix J: Evaluation of Addiction Treatment Services Benefit

Appendix K: Budget Neutrality

Clinical Review of Requested Substance Use Disorder Treatment Service

Fax Form to Respective Plan Using Contact Information Below

PLEASE TYPE or WRITE LEGIBLY
or request will be returned as unable to process

MEMBER INFORMATION	
Member Name:	DOB:
Member ID:	If retroactively enrolled, provide enrollment date:

PROVIDER INFORMATION	
Provider Group/Clinic:	Contact:
Phone:	Fax:
Street Address:	City | State | Zip:
Provider ID/NPI:	
ESTIMATED DURATION OF THIS EPISODE OF CARE:	

DIAGNOSES (Primary and any applicable co-occurring diagnoses)
1.
2.
3.
4.

SUBSTANCE USE DISORDER TREATMENT HISTORY
(Describe other ASAM Levels of Care tried in past 12 months)

ASAM Level of Care	Name of Provider	Duration	Approximate Dates	Outcome

ASAM LEVEL OF CARE REQEUSTED

○	ASAM Level 2.1 | Intensive Outpatient (IOP)	○	ASAM Level 2.5 | Partial Hospitalization (PHP)	○	ASAM Level 3.1 | Clinically Managed Low-Intensity Residential Services
○	ASAM Level 3.3 – 3.5 | Clinically Managed High-Intensity Residential Services	○	ASAM Level 3.7 | Medically Monitored Inpatient Services	○	ASAM Level 4 | Medically Managed Inpatient Services
○	Other				

MEDICATION		
Please list medications, dosage and frequency below.	Not applicable	
Name	Dosage	Frequency

4/1/16

REQUESTED CODES (Include Amount and Modifier)							
Code		Units/ Visits	Modifier	Code		Units/ Visits	Modifier
○	H0015 Intensive Outpatient			○	Other Code: (please write)		
○	H0018 Short-Term Residential (1-30 days)			○	Other Code: (please write)		
○	H0019 Long-Term Residential (31+ days)			○	Other Code: (please write)		
○	Inpatient Hospitalization			○	Other Code: (please write)		

ASSESSMENT AND SCORING	
DIMENSION 1 | Acute Intoxication and/or Withdrawal Potential	
○	No withdrawal (Move to the next dimension)
○	Moderate withdrawal symptoms not requiring 24-hour intensive or acute hospital setting (Possible referral to RTC)
○	Patient has the potential for life threatening withdrawal (Immediate referral to medically monitored detox)
○	Patient has life threatening withdrawal symptoms, possible or experiencing seizures or DT's or other adverse reactions are imminent (Immediate referral to acute hospital setting)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 2 | Biomedical Conditions/Complications	
○	None or very stable (OP)
○	None or not sufficient to distract from treatment (IOP)
○	None or not sufficient to distract from treatment (PHP)
○	None/stable or receiving concurrent treatment – moderate stability (PHP/IOP/Other services)
○	Severe instability requires 24-hour medical care in licensed medical facility. May be the result of life threatening withdrawal or other co-morbidity (Immediate referral to acute care)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 3 | Emotional/Behavioral/Cognitive Conditions	
○	None or very stable (OP)
○	Needs structure to focus on recovery as these conditions can distract from recovery efforts (IOP/PHP)
○	Moderate stability, cognitive deficits, impulsive or unstable MH issues (RTC)

○	Severe instability high safety risk, very unstable may be related to substance use or in addition to substance requires 24-hour acute psychiatric care (Refer to inpatient services)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 4 | Readiness to Change	
○	Readiness for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management (OP)
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change (IOP)
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment almost daily to promote change (PHP)
○	Has marked difficulty with treatment or opposition due to functional issues or there has been ongoing dangerous consequences (RTC)
○	Poor impulse control, continues to use substances despite severe negative consequences (medical, physical or situational) and requires a 24-hour structured setting (Rehabilitation)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 5 | Relapse, Continued Use or Continued Problem Potential	
○	Minimal support required to control use, needs support to change behaviors (OP)
○	High likelihood of relapse/continued use or addictive behaviors, requires services several times per week (IOP)
○	Intensification of addition and/or mental health issues and has not responded to active treatment provided in a lower levels of care. High likelihood of relapse, requires treatment almost daily to promote change (PHP)
○	Does not recognize the severity of treatment issues, has cognitive and functional deficits (RTC)
○	Unable to control use, requires 24-hour supervision, imminent dangerous consequences (Rehabilitation)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 6 | Recovery/Living Environment	
○	Supportive recovery environment and patient has skills to cope with stressors (OP)
○	Not a fully supportive environment but patient has some skills to cope (IOP)
○	Not a supportive environment but can find outside supportive environment (PHP)
○	Environment is dangerous, patient needs 24-hour structure to learn to cope (RTC)
○	Environment is imminently dangerous, patient lacks skills to cope outside of a highly structured environment (Rehabilitation)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	

Based on the clinical review, please indicate the ASAM recommended level of care :							
○	Level 2.1	○	Level 3.1	○	Level 3.7	○	Other
○	Level 2.5	○	Level 3.3 – 3.5	○	Level 4		

Is the ASAM recommended level of care different than what is requested?	○ Yes ○ No
If yes, please provide the reason for the variance and include supporting clinical documentation:	

SIGNATURE

Reviewer Name (print):	
Signature/Credential:	**Date:**

PLEASE FAX FORM TO THE DESIGNATED HEALTHCARE PLAN USING THE CONTACT INFORMATION BELOW

CONTACT INFORMATION				
Managed Care Organization	Contact	Phone Number	Fax Number	E-mail Address
Aetna Better Health	Stephanie Hargan	(800)279-1878	(866)669-2454	hargans@aetna.com
Anthem		(800)901-0020 (for inpatient)	(877)434-7578 (for inpatient) (800)505-1193 (for outpatient)	N/A
INTotal Health	Cheryl Ricciardi	(855)323-5588	(844)462-7376	SUDrequest@inova.org
Kaiser	Linda Bloch	(301)625-6102	(301)625-5560	Linda.l.bloch@kp.org
Magellan		(800)424-4046		
Optima	N/A	(800)648-8420	(844)723-2096 (757)431-7763	N/A
Virginia Premier Complete Care	N/A	(800)727-7536 (toll –free) (804)819-5151 (local)	(877)685-5732 (toll-free) (804)343-0307 (local)	N/A

CONTACT INFORMATION				
Medicare-Medicaid Plan	Contact	Phone Number	Fax Number	E-mail Address
Anthem Healthkeepers	N/A	(800)901-0020 (for inpatient)	(877)434-7578 (for inpatient) (800)505-1193 (for outpatient)	N/A
Humana Integrated Gold	N/A	(855)765-9704		N/A
Virginia Premier Complete Care	N/A	(800)727-7536 (toll –free) (804)819-5151 (local)	(877)685-5732 (toll-free) (804)343-0307 (local)	N/A

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Community Based Care							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H0006 (HO)	Alcohol and/or drug services; Case management (Bachelors Level)	Targeted case management services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit = 15 minutes (208 units)	$16.00	No	
H0006 (HD)	Alcohol and/or drug services; Case management (Masters/Licensed Level)	Targeted case management services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit = 15 minutes (208 units)	$24.00	No	
H0038	Peer support services	Self help/Peer Services. Peer provided services to initiate clinical service utilization and self-determination strategies	1	1 unit = 15 minutes	$13.50	Yes	
S9445	Peer support services Patient education - individual	Patient education; non-physician provider, individual, per session	1	1 unit = 15 minutes	Pending	Yes	to be defined later
S9446	Peer support services Patient education - group	Patient education; non-physician provider, group, per session	1	1 unit = 15 minutes	Pending	Yes	to be defined later
H0015	Intensive outpatient	Structured program delivering 9-19 hours per week, before/after work/school, in evening and/or weekends to meet complex needs of people with addition and co-occuring conditions.	2.1	1 unit = 1 day	$288.00	Yes, URGENT: Review within 72 hours, PA retroactive	Minimum of 9 hours per week adult Minimum of 6 hours per week adolescent MD visit separate
H0035	Partial Hospitalization	20 or more hours of clinically intensive programming per week with a planned format of individualized and family therapies.	2.5	1 unit = 1 day (6 Hours per day)	$576.00	Yes, URGENT: Review within 72 hours, PA retroactive	Minimum of 20 service hours per week
H0007	*SUD crisis intervention –non-residential*	*Immediate Crisis Intervention Services (No ASAM LOC)*	*Registration*	*1 unit = 15 minutes*	*$25.00*	*Yes*	***SUD Crisis services will be replaced by MH Crisis Intervention***

Medication Assisted Treatment (MAT) / Opioid Treatment Services (OTS) / Office Based Opioid Treatment (OBOT) and Withdrawal Management							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
G9012 (HO)	(OBOT) Medication Assisted Treatment (MAT) care coordination (Bachelors level)	OBOT Care coordination to manage MAT treatment	OTS/OBOT	1 unit=15 minutes (208 units)	$16.00	No	Used in OBOT setting
G9012 (HD)	(OBOT) Medication Assisted Treatment (MAT) care coordination (Masters/Licensed level)	OBOT Care coordination to manage MAT treatment	OTS/OBOT	1 unit=15 minutes (208 units)	$24.00	No	Used in OBOT setting
H0006 (HO)	Alcohol and/or drug services - Substance abuse case management (Bachelors Level)	Targeted Case Management Services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit=15 minutes (208 units)	$16.00	No	Used in OTS Setting or by Virginia DBHDS licensed providers

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Medication Assisted Treatment (MAT) / Opioid Treatment Services (OTS) / Office Based Opioid Treatment (OBOT) and Withdrawal Management continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H0006 (HD)	Alcohol and/or drug services - Substance abuse case management (Masters/Licensed level)	Targeted Case Management Services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit=15 minutes (208 units)	$24.00	No	Used in OTS Setting or by Virginia DBHDS licensed providers
H0020	Opioid treatment services	Opioid Treatment - individual, group counseling and family therapy and medication administration	OTS/OBOT	1 unit=15 minutes (208 units)	$24.00	No	
H0014	Medication Assisted Treatment (MAT) induction	Alcohol and/or drug services; ambulatory detoxification Withdrawal Management-Induction	OTS/OBOT	Per encounter	*TBD*	No	*Will model after CPT rates for new and existing adult patients.*
99201-99215	Evaluation and management visit	Physician Services	OTS/OBOT	CPT values	$97.95 to 160.35	No	CPT rates as of July 1, 2016: Age <21 = $112.14 to 160.35 Age >20 = $97.95 to 140.06
G0477 - G0479	Urine drug screen	Toxicology/Lab	OTS/OBOT	CPT values	$14.96 to 79.25	No	G0477-$14.86, G0478-$19.81, G0479-$79.25
G0480 - G0483	Definitive drug testing	Toxicology/Lab	OTS/OBOT	CPT values	$79.74 to 215.23	No	*Proposed limit of 50/year* G0480-$79.74, G0481-$122.99, G0482-$166.03, G0483-$215.23
S0109 J0571 J0572 J0573 J0574 J0575	Medication administration in clinic	Medication administration by provider	1WM-2WM and other settings 2.1-3.1	Per Diem- Bundled Services	S0109 $0.26/5 mg *J codes (TBD)*	No	MD visits, counseling, case management and medical services allowed concurrently. *S0109 Methadone oral 5 mg* *J0571 Buprenorphine, oral, 1 mg* *J0572 Buprenorphine/naloxone oral <=3 mg* *J0573 Buprenorphine/naloxone oral >=3 mg but <= 6 mg* *J0574 Buprenorphine/naloxone oral >=6 mg but <=10 mg* *J0575 Buprenorphine/naloxone oral >10 mg*
Q3014 – GT	Telehealth originating site facility fee		1WM-2WM	Per Visit	$20.00	No	
99211-99215	Evaluation and management services established patient	Evaluation and Management services established patient	1WM-2WM	N/A	$13.48 to 112.14	No	CPT rates as of July 1, 2016: Age <21 = $15.43 to 112.14 Age >20 = $13.48 to 97.95
99201-99205	Evaluation and management services new patient	Evaluation and Management services new patient	1WM-2WM	N/A	$29.84 to 160.35	No	CPT rates as of July 1, 2016: Age <21 = $34.16 to 160.35 Age >20 = $29.84 to 140.06
G0477-G0479	Urine drug screen	Toxicology/Lab	OTS/OBOT 1WM-2WM	CPT values	$14.96 to 79.25	No	G0477-$14.86, G0478-$19.81, G0479-$79.25
G0480-G0483	Definitive drug testing	Toxicology/Lab	OTS/OBOT 1WM-2WM	CPT values	$79.74 to 215.23	No	*Proposed limit of 50/year* G0480-$79.74, G0481-$122.99, G0482-$166.03, G0483-$215.23

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Medication Assisted Treatment (MAT) / Opioid Treatment Services (OTS) / Office Based Opioid Treatment (OBOT) and Withdrawal Management continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
90832 – alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	Outpatient service	1WM-2WM	Varies based on MD face time with patient	$54.67	No	
90833 – alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1WM-2WM	Varies based on MD face time with patient	$56.51	No	List separately in addition to the code for the primary procedure
90834 – alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	Outpatient service	1WM-2WM	N/A	$72.69	No	
90836 – alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1WM-2WM	N/A	$71.78	No	List separately in addition to the code for the primary procedure
90837 – alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	Outpatient service	1WM-2WM	N/A	$109.04	No	
90838 – alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1WM-2WM	N/A	$94.68	No	List separately in addition to the code for the primary procedure
90846 alone or GT	Family psychotherapy (without patient present)	Outpatient service	1	45 minutes to 1 hour	$88.27	No	
90847 – alone, GT or HF if SA	Family psychotherapy (with patient present)	Outpatient service	1WM-2WM	45 minutes to 1 hour	$91.32	No	
90853 – alone, GT or HF if SA	Group psychotherapy (other than multi-family)	Outpatient service	1WM-2WM	45 minutes to 1 hour	$21.99	No	Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity.
90863 – alone, GT or HF if SA	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	Outpatient service	1WM-2WM	Use in conjunction with 90832, 90834, 90837	$21.99	No	List separately in addition to the code for the primary procedure

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Residential and Inpatient Treatment							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H2034	Clinically managed low intensity residential services	Alcohol and/or drug abuse halfway house services, per diem. Supportive living environment with 24-hour staff and integration with clinical services; at least 5 hours of low-intensity treatment per week.	3.1	1 unit = 1 day	Urban: $180.00 Rural: $162.00	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Daily rate includes all services. Additional services consist of IOP or MAT which can be billed separately.
H0010 Rev 1002	Clinically managed population-specific high intensity residential services	Alcohol and /or drug services; sub-acute detoxification (residential addiction program inpatient). ***Adults only*** -Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed MH professionals.	3.3	1 unit = 1 day	$393.50	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications
H0010 Rev 1002	Clinically managed high-intensity residential services **(Adult)** Clinically managed medium-intensity residential services **(Adolescent)**	Alcohol and /or drug services; sub-acute detoxification (residential addiction program inpatient). Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents. Staffed by licensed/credentialed clinical staff including addiction counselors, LCSWs, LPCs, physicians/physician extenders, and credentialed MH professionals.	3.5	1 unit = 1 day	$393.50	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications
H2036 Rev 1002	Medically monitored intensive inpatient services **(Adult)** Medically monitored high intensity inpatient services **(Adolescent)**	Alcohol and/or other drug treatment program, per diem. Planned and structured regimen of 24 hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting consisting of freestanding facility or a specialty unit in a general or psychiatric hospital or other licensed health care facility.	3.7	1 unit = 1 day	TBD *Allowance for separate facility, psychiatric inpatient and RTC rates.*	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Residential and Inpatient Treatment continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H0011 or Rev 1002	Medically managed intensive inpatient services	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient). Medically Managed Intensive-Inpatient Services consist of 24 hour nursing care and daily physician care for severe, unstable problems in dimensions 1, 2 or 3. Counseling available.	4.0	1 unit = 1 day	DRG	Yes URGENT – Telephonic Approval Within 24 hours (1 calendar day)	Hospital Services Per Diem

Outpatient Treatment							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
90791 - alone, GT, or HF if SA	Psychiatric diagnostic evaluation	Outpatient service	1	1 unit per rolling 12 months for same provider	$112.70	No	Use 90785 in conjunction with 90791 or 90792 when the diagnostic evaluation includes interactive complexity services.
90792 - alone or GT	Psychiatric diagnostic evaluation with medical service	Outpatient service	1	1 unit per rolling 12 months for same provider	$124.92	No	Use 90785 in conjunction with 90791 or 90792 when the diagnostic evaluation includes interactive complexity services.
90785 (HF if SA)	Interactive complexity service add-on code to office visits	Outpatient service	1		$11.91	No	List separately in addition to the code for primary procedure.
99408	Alcohol and/or substance (other than tobacco) abuse structured screening: 15 - 30 minutes	Outpatient service	1	1 unit = 1 Assessment 3 screenings per provider, per member	Ages <21=$25.83 >20=$23.82	No	
99409	Alcohol and/or substance (other than tobacco) abuse structured screening: greater than 30 minutes	Outpatient service	1	1 unit = 1 Assessment 3 screenings per provider, per member	Ages <21=$50.35 >20=$46.45	No	
90832-alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	Outpatient service	1	CPT unit values	$54.67	No	
90833-alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1	CPT unit values	$56.51	No	List separately in addition to the code for primary procedure.
90834-alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	Outpatient service	1	CPT unit values	$72.69	No	

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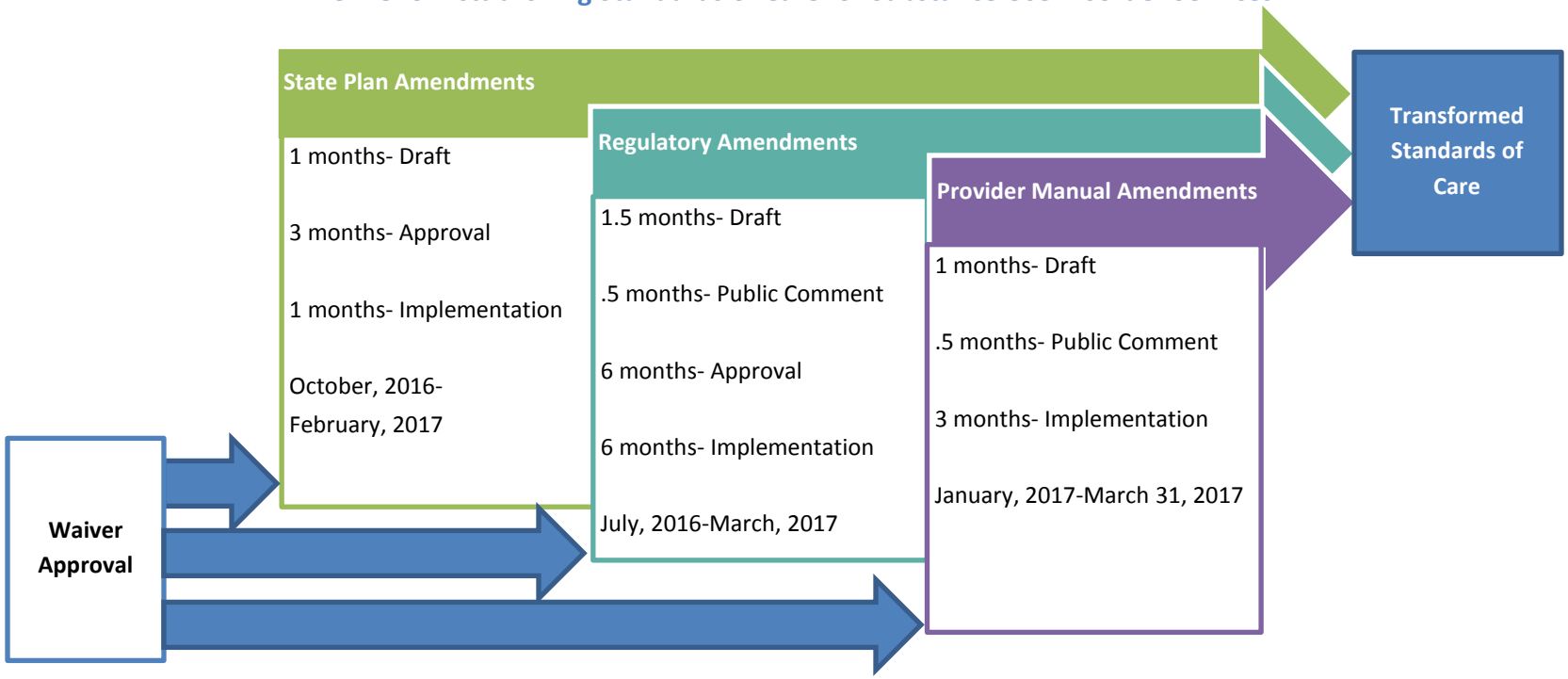
Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Outpatient Treatment continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
90836-alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1	CPT unit values	$71.78	No	List separately in addition to the code for primary procedure.
90837-alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	Outpatient service	1	CPT unit values	$109.04	No	
90838-alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1	CPT unit values	$94.68	No	List separately in addition to the code for primary procedure.
90846 alone or GT	Family psychotherapy (without patient present)	Outpatient service	1	CPT unit values	$88.27	No	
90847 alone or GT	Family psychotherapy (with patient present)	Outpatient service	1	CPT unit values	$91.32	No	
90853 alone or GT	Group psychotherapy (other than multi-family)	Outpatient service	1	CPT unit values	$21.99	No	Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity.
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	Outpatient service	1WM-2WM	Use in conjunction with 90832, 90834, 90837	$21.99	No	List separately in addition to the code for the primary procedure

Timeline for Establishing Standards of Care for Substance Use Disorder Services



Item 306, 2016 Virginia Appropriation Act

MMMM.1. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall amend the state plan for medical assistance and/or seek federal authority through an 1115 demonstration waiver, as soon as feasible, to provide coverage of inpatient detoxification, inpatient substance abuse treatment, residential detoxification, residential substance abuse treatment, and peer support services to Medicaid individuals in the Fee-for-Service and Managed Care Delivery Systems. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall make programmatic changes in the provision of all Substance Abuse Treatment Outpatient, Community Based and Residential Treatment services (group homes and facilities) for individuals with substance abuse disorders in order to ensure parity between the substance abuse treatment services and the medical and mental health services covered by the department and to ensure comprehensive treatment planning and care coordination for individuals receiving behavioral health and substance use disorder services. The department shall take action to ensure appropriate utilization and cost efficiency, and adjust reimbursement rates within the limits of the funding appropriated for this purpose based on current industry standards. The department shall consider all available options including, but not limited to, service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates for the following Medicaid services: substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse case management, opioid treatment, substance abuse day treatment, and substance abuse intensive outpatient. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance and any waivers thereof to include peer support services to children and adults with mental health conditions and/or substance use disorders. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria and provider qualifications. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

DBHDS Licensing and ASAM Level of Care Crosswalk

CONTENTS

ASAM LOC	DBHDS LICENSE	CARE COMPONENT	ASAM REQUIREMENTS	DBHDS REQUIREMENTS
2.1 Intensive Outpatient	Substance Abuse Intensive Outpatient Service For Adults, Children, and Adolescents	Setting	Addiction education and treatment programs offered in any appropriate setting that meets state licensure or certification criteria	Usually in a clinic or similar facility or in another location. Non-residential setting. 12VAC35-105-260. All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose.
		Service Delivery Examples	• After-school, day or evening, and/or weekend intensive outpatient programs	• This care and treatment may include counseling, rehabilitation, to individuals on an hourly schedule, on an individual, group, or family basis.
		Admission Criteria	1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable or are being addressed concurrently and will not interfere with treatment. 3. If emotional, behavioral, or cognitive conditions are present, patient must be admitted to either a co-occurring capable or co-occurring enhanced program. 4. Patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed; **OR** patient's perspective inhibits his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions 5. Patient is experiencing an intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment or there is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services • Patient's continued exposure to current school, work, or living environment will render recovery unlikely; **OR** patient lacks skills, social contacts, has unsupportive social contacts that jeopardize recovery.	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. Individuals admitted may have: • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability.

				○ Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. • **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care should have been seen in Level 1 services prior to admission; **or** • Direct admission to Level 2 is advisable for the patient based on the biopsychosocial assessment, treatment at a lower level of care is adjudged insufficient to stabilize the patient's condition. ○ Stable bio-medical condition **and** a co-occurring emotional, behavioral, or cognitive condition(s) **and** problems in at least **one** of the following areas: Readiness to Change; Relapse, Continued Use or Continued Problem Potential; or Recovery Environment. • Patient has met treatment objectives at a higher level of care.	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

		Staffing	• Based on daily structured program schedule	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Staff Credentials	• Credentialed addiction treatment professionals & addiction-credentialed physicians who assess and treat SUDs. • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals • Generalist physicians may be involved in providing general medical evaluations and concurrent/integrated general medical care during the provision of Level 2 addiction care.	12VAC35-105-590. • Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. • Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation, mental health supports shall be provided by a (Qualified Mental Health professional) QMHP. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse

				with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	• Telephone consultation within 24 hours by telephone and within 72 hours in person. • Emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	Services provide essential addiction education and treatment components while allowing patients to apply skills with “real world” environments.	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	Provides 9-19 hours per week of structured programming	Treatment provided in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide.
		Types Clinical Services	Individual and group counseling, medication management, family therapy, psychoeducational	Substance abuse intensive outpatient services may but are not limited to include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.
		Services	• Biopsychosocial assessment • Individualized treatment planning • occupational & recreational therapies • Motivational interviewing, enhancement, and engagement strategies • Random toxicology testing	Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services.
		Support Systems	• Direct affiliation with, or close coordination through referral to, more and less intensive levels of care and supportive housing. • Ability to arrange for needed laboratory and toxicology services. • Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications	Includes Case Management and Coordination of Services; Includes Family Therapy and Individual monitoring; Completion of ISP 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

				12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-1250. • Employees or contractors providing case management services shall have knowledge of: Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; Identifying and documenting how resources, services, and natural supports such as family can be utilized to promote achievement of an individual's personal habilitative or rehabilitative and life goals Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and

				representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs;
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
2.5 Partial Hospitalization Treatment	Substance Abuse Partial Hospitalization or Substance Abuse/Mental Health Partial Hospitalization	Setting	Addiction education and treatment programs with direct access to psychiatric, medical, and laboratory services offered in any appropriate setting that meets state licensure or certification criteria	*DBHDS Licensing regulations does not specify a specific setting for partial hospitalization programs.* 12VAC35-105-260. • All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose.
		Service Delivery Examples	Day treatment programs	Services designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay.
		Admission Criteria	1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable or are being addressed concurrently and will not interfere with treatment. 3. If emotional, behavioral, or cognitive conditions are present, patient must be admitted to either a co-occurring capable or co-occurring enhanced program. 4. Patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed; **OR** patient's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. 5. Patient is experiencing an intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; **OR** there is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services 6. Patient's continued exposure to current school, work, or living environment will render recovery unlikely. The patient lacks the resources or skills to maintain adequate functioning; **OR** Family member and/or significant others who live with the patient are not supportive of his/her recovery goals, or are passively opposed to his/her treatment.	Individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting. 12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. ○ Needing "Co-occurring services" - individually planned therapeutic

				treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care should have been seen in Level 1 services prior to admission; **OR** • Direct admission to Level 2 is advisable for the patient based on the biopsychosocial assessment, treatment at a lower level of care is adjudged insufficient to stabilize the patient's condition. ○ Stable bio-medical condition **and** a co-occurring emotional, behavioral, or cognitive condition(s) **and** problems in at least **one** of the following areas: Readiness to Change; Relapse, Continued Use or Continued Problem Potential; or Recovery Environment. • Patient has met treatment objectives at a higher level of care.	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	• Based on daily structured program schedule	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the

				types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Staff Credentials	• Credentialed addiction treatment professionals & addiction-credentialed physicians who assess and treat SUDs. • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals • Generalist physicians may be involved in providing general medical evaluations and concurrent/integrated general medical care during the provision of Level 2 addiction care.	12VAC35-105-590. • Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. • Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation, mental health supports shall be provided by a (Qualified Mental Health professional) QMHP. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at

				least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	• Telephone consultation within 8 hours by telephone and within 48 hours in person. • Emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	• Services provide essential addiction education and treatment components while allowing patients to apply skills with “real world” environments.	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	• 20 or more hours of clinically intensive programming per week.	Time-limited active treatment interventions that are more intensive than outpatient services.
		Types Clinical Services	• Individual and group counseling, medication management, family therapy, psychoeducational	Services may include but are not limited to multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.
		Services	• Biopsychosocial assessment • Individualized treatment planning • Occupational & recreational therapies • Motivational interviewing, enhancement, and engagement strategies • Random toxicology testing	May include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services.
		Support Systems	• Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing. • Ability to arrange for needed laboratory and toxicology services. • Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications	Includes Case Management and Coordination of Services; Can includes Family Therapy and Individual monitoring; Completion of ISP 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's

				scheduled discharge date. 12VAC35-105-1250. • Employees or contractors providing case management services shall have knowledge of: Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; Identifying and documenting how resources, services, and natural supports such as family can be utilized to promote achievement of an individual's personal habilitative or rehabilitative and life goals Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills;

				13. Housing arrangements; 14. Ability to access services including transportation needs;
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
3.1 Clinically Managed Low Intensity Residential Services	Mental Health & Substance Abuse Group Home Service for Adults or Children; Substance Abuse Halfway House for Adults;	Setting	• Provides 24-hour structure and support • Provides a 24-hour supportive living environment	A congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. 12VAC35-105-340. • No more than two individuals shall share a bedroom. Definition(s): **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, **group or community homes,** supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and substance abuse residential treatment for women and children. **"Group home or community residential service**" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.
		Service Delivery Examples	Halfway house, group homes or other supportive living environment with 24-hour staff and close integration with clinical services *Note: This level does not describe or include sober houses, boarding houses, or group homes where treatment services are not provided.*	Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring.
		Admission Criteria	Patient meets specifications in **each** of the six dimensions: 1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable and the individual is capable of self-administering medication; or the condition requires medical monitoring, which can be provided by the program or through an established arrangement with another provider 3. The individual may not have any significant emotional, behavioral, or cognitive conditions and impairment. However, if any is present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. The individual acknowledges the existence of a substance use problem and is sufficiently ready to change and cooperative enough to respond to treatment at Level 3.1; **OR** is assessed as appropriately placed at Level 1 or 2 and is receiving Level 3.1 concurrently; **OR** is assessed as not likely to succeed in an OP setting, therefore, requires a 24-hr structured milieu to promote treatment progress and recovery; OR individual's perspective impairs his or her ability to make behavior changes without a structured environment. 5. The individual demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning; and, is in imminent danger of relapse without 24-hour structure; **OR** individual	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other

			understands his or her addiction and/or mental disorder, but is at risk of relapse in a less structured level of care; **OR** individual is at high risk of substance use, addictive behavior or cognitive consequences in the absence of close 24-hour structured support 6. The individual is able to cope, for limited periods of time, outside the 24-hr structure of Level 3.1 in order to pursue clinical, vocational, educational, and community activities; AND has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in an less intensive level of care; **OR** the individual lacks social contacts or has high-risk social contacts; **OR** individual's social network involves living in an environment so highly invested in alcohol or other drug use that the individual's recovery goals are assessed as unachievable **OR** continued exposure to the individual's school, work, or living environment makes recovery unlikely, and individual has insufficient resources and skills to maintain an adequate level of functioning outside of a 24-hr supportive environment; **OR** the patient is in danger of victimization by another and, thus, requires 24-hr supervision.	appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. o Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care should have been seen in Level 1 or 2 services prior to admission for multidimensional assessment and differential diagnosis	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs

				and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	• 24 hour staff	Provides 24-hour supervision of residents
		Staff Credentials	• Allied health professional staff, such as counselor aides or group living workers who are on-site 24/7, or as required by licensing standards • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUDs and their treatment and who are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Physician Coverage	• Telephone or in-person consultation with a physician and emergency services available 24/7 • An addiction physician should review admission decisions to confirm the clinical necessity of services	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	• Services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies • They promote personal responsibility and reintegration of the individual into the network systems of work, education and family life	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	• 5 hours of planned, clinical activities of professionally directed treatment per week	Not specified in DBHDS Licensure requirements
		Types Clinical Services	• Treatment is characterized by services such as individual, group and family therapy; medication management; and psychoeducation	Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.
		Services	• Clinically directed treatment • Addiction pharmacotherapy	Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

			• Random drug screening • Motivational enhancement and engagement strategies • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Recovery support services • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder • Self-help meetings are available on-site, or easily accessible in the local community	
		Support Systems	• Direct affiliations with other levels of care, or close coordination through referral to more and less intensive services (such as IOP, vocational, literacy training and adult education) • Ability to arrange for needed procedures, including laboratory and toxicology tests • Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications	12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status;

				12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
3.3 Clinically Managed Population-Specific High Intensity Residential Services for special populations with cognitive disabilities	Supervised Residential Treatment Services for Adults; Substance Abuse Residential Treatment for Adults	Setting	• Provides 24-hour service and supports • Freestanding, appropriately licensed facility located within a community setting or a specialty licensed health care facility	In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility. Definition(s): **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and **substance abuse residential treatment for women and children.**
		Service Delivery Examples	• Therapeutic rehabilitation facility or a traumatic brain injury program	Providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders
		Admission Criteria	Patient meets specifications in **each** of the six dimensions: 1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable and the individual is capable of self-administering medication; or the condition requires medical monitoring, which can be provided by the program or through an established arrangement with another provider. 3. If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. The intensity and chronicity of the SUD or the patient's cognitive impairment is such that he or she has little awareness of the need for treatment or continuing care; **OR** despite experiencing consequences of the SUD or mental health problem the patient has marked difficulty understanding the relationship between his or her SUD, addiction, mental health or life problems and impaired coping; **OR** the patient's continued us poses a danger of harm to self or others, and he or she demonstrates no awareness of the need to address the severity of his or her addiction or recognize the need for treatment; **OR** the patient's perspective impairs his or her ability to make	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to

			behavior changes without repeated, structured, clinically motivated interventions developed in a 24-hour milieu. 5. Patient does not recognize relapse triggers and has little awareness of the need for continuing care. He or she is in imminent danger of continued substance use or mental health problems without 24-hour monitoring and structure; **OR** patient is experiencing an intensification of symptoms of his or her substance SUD or mental disorder, and his or her level of functioning is deteriorating despite an amendment to the treatment plan; **OR** patient's cognitive impairment has limited his or her ability to identify and cope with relapse triggers and high-risk situations. Patient requires relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively, in a setting that provides 24-hour structure and support; **OR** Despite recent, active participation in treatment at a less intensive level of care, the patient continues to use substances or to deteriorate psychiatrically with imminent consequences. 6. Patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in an less intensive level of care; **OR** significant danger of victimization and thus requires 24-hour supervision; **OR** individual's social network involves living in an environment so highly invested in alcohol or other drug use that the individual's recovery goals are assessed as unachievable; **OR** patient need staff monitoring to assure his or her safety and well-being.	the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. ○ Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care meet diagnostic criteria for moderate or severe SUD	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. 12VAC-35-105-740 • A physical examination shall be administered within 24 hours of an

				individual's admission. The physical examination shall include, at minimum: ○ General physical condition (history and physical); ○ Evaluation of communicable diseases; ○ Recommendations for further diagnostic tests and treatment, if appropriate; ○ Other examinations that may be indicated; and ○ The date of examination and signature of a qualified practitioner Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	24 hour staff	Provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis
		Staff Credentials	• Physicians • Allied health professional staff, such as counselor aides or group living workers who are on-site 24/7, or as required by licensing standards. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day. • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUDs and their treatment and who are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Physician Coverage	• Telephone or in-person consultation with a physician and emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

				12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	Services address the effects of the substance use or a co-occurring disorder that has resulted in cognitive impairment and the impact on the individual's life is so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective.	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	• Daily • Individualized based on the extent of reduced cognitive functioning	Not Specified in DBHDS Licensing Regulations
		Types Clinical Services	Treatment is characterized by services such as individual, group and family therapy; medical and nursing; physical therapy; medication management; and psychoeducation	Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting
		Services	• Biopsychosocial assessment • Individualized treatment planning • Clinically directed treatment • Addiction pharmacotherapy • Random drug screening • Art, music or movement therapies • Vocational rehabilitation • Cognitive and behavioral therapies • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Recovery support services • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder	Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.
		Support Systems	• Direct affiliations with other levels of care, or close coordination through referral to more and less intensive services (such as IOP, vocational, literacy training and adult education) • Ability to arrange for needed procedures, including laboratory and toxicology tests • Medical, psychiatric, psychological services available through consultation or referral.	12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24

				hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

DBHDS Licensing and ASAM LOC Crosswalk

ASAM LOC	DBHDS LICENSE	CARE COMPONENT	ASAM REQUIREMENTS	DBHDS REQUIREMENTS
3.5 Clinically-Managed, Medium/High Intensity Residential Treatment	Substance Abuse Residential Treatment Services for Adults or Children; or Psychiatric Unit	Setting	• Provides 24-hour service and structured support • Freestanding, appropriately licensed facility located within a community setting or a specialty licensed health care facility • Prisons or secure community settings for inmates released from prison as a step down	In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility. Definition(s): **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and **substance abuse residential treatment for women and children.** **"Children's residential facility" or "facility"** means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia **Acute psychiatric hospital** "Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric, maternity). (12VAC5-410-10) **Psychiatric unit within an acute care general hospital or Acute psychiatric hospital –** An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20)
		Service Delivery Examples	• Residential treatment center or a therapeutic community	Providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders Free standing psychiatric or substance abuse hospital, or an acute care facility with a specialized psychiatric or substance use treatment unit. An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20) In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility.
		Admission Criteria	Patient meets specifications in **each** of the six dimensions: 1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed; **OR** current biomedical condition is not severe enough to warrant inpatient treatment, but warrants medical monitoring, which can be provided by the program or through an established arrangement with another provider.	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse

			2. Biomedical problems are stable and the individual is capable of self-administering medication; or the condition requires medical monitoring, which can be provided by the program or through an established arrangement with another provider. 3. If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. The intensity and chronicity of the SUD or the patient's mental health problems are such that he or she has limited insight or little awareness of the need for treatment or continuing care; **OR** despite experiencing consequences of the SUD or mental health problem the patient has marked difficulty understanding the relationship between his or her SUD, addiction, mental health or life problems and impaired coping, or blaming others for his or her addiction problem; **OR** patient demonstrates passive or active opposition to addressing the severity of his or her mental or addiction problem, or does not recognize the need for treatment; **OR** patient requires structured therapy and a 24-hours programmatic milieu to promote treatment progress and recovery, because motivation interventions have not succeeded at less intensive levels of care; **OR** patient's perspective impairs his or her ability to make behavior changes without repeated, structured, clinically motivated interventions developed in a 24-hour milieu; **OR** despite recognition of a SUD and understanding the relationship between his or her use, addiction, life problems, the patient expresses little to no interest in changing; **OR** Patient attributes his or her alcohol, drug, addictive, or mental problem to other persons or external events, rather than to a substance use or addictive or mental disorder. 5. The patient requires 24-hour monitoring and structured support. Patient does not recognize relapse triggers and has little awareness of the need for continuing care and is, therefore, not committed to treatment. His or her continued substance use poses an imminent danger of harm to self or others in the absence of 24-hour monitoring and structured support; **OR** patient's psychiatric condition is stabilizing; however, patient is unable to control his or her use of alcohol, other drugs, and/or antisocial behaviors. The patient has limited ability to interrupt the relapse process or to use peer supports when at risk for relapse; **OR** patient is experiencing psychiatric or addiction symptoms, insufficient ability to postpone immediate gratification and other drug-seeking behaviors. Poses an imminent danger of harm to self or others in the absence of 24-hour monitored support; **OR** patient is in danger of relapse or continued use, with dangerous emotional, behavioral, or cognitive consequences, as a result of a crisis situation; **OR** Despite recent, active participation in treatment at a less intensive level of care, the patient continue to use alcohol or other drugs, or to deteriorate psychiatrically, with imminent serious consequences; **OR** patient demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. The patient's imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment.	(substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. o Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. 12VAC35-46-640. (Children's Residential Regulations) • The facility shall have written criteria for admission that shall include: 1. A description of the population to be served; 2. A description of the types of services offered; 3. Intake and admission procedures; 4. Exclusion criteria to define those behaviors or problems that the facility does not have the staff with experience or training to manage; and 5. Description of how educational services will be provided to the population being served. • The facility shall accept and serve only those children whose needs are compatible with the services provided through the facility unless a child's admission is ordered by a court of competent jurisdiction.

			6. Patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in an less intensive level of care; **OR** individual's social network includes regular users of alcohol, tobacco, and/or other drugs, such that the individual's recovery goals are assessed as unachievable; **OR** patient's social network involves living with an individual who is a regular user, addicted user or dealer of alcohol and/or other drugs, or the living environment is so invested in alcohol and/or other drug use that his or her recovery goals are assessed as unachievable; **OR** patient is unable to cope, for even limited periods of time, outside of 24-hour care.	
		Admission Process	• Patients admitted to this level of care meet diagnostic criteria for moderate or severe SUD • Patients have multiple limitations such as psychological problems, impaired functioning, and demonstrate antisocial behaviors. • Patients have a pattern of relapse-reoffending-incarceration-release-relapse • Patients to this level of care should have been seen in Level 1 or 2 services prior to admission for multidimensional assessment and differential diagnosis	**Psychiatric unit within a general hospital and acute psychiatric hospital** An initial individualized services plan (ISP) shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs. (12VAC35-105-660 B) 12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. (12VAC-35-105-740) • A physical examination shall be administered within 24 hours of an individual's admission. The physical examination shall include, at minimum: ○ General physical condition (history and physical); ○ Evaluation of communicable diseases; ○ Recommendations for further diagnostic tests and treatment, if appropriate; ○ Other examinations that may be indicated; and ○ The date of examination and signature of a qualified

practitioner

12VAC35-46-10 (Children Residential Regulations)

- The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms.

12VAC35-46-630. (Children Residential Regulations)

- Acceptance of children. Children shall be accepted only by court order or by written placement agreement with legal guardians.

12VAC35-46-710. (Children Residential Regulations)

- Admission shall be based on evaluation of an application for admission. The requirements of this section do not apply to court-ordered placements or transfer of a resident between residential facilities located in Virginia and operated by the same sponsor.
- Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine:
  1. The educational needs of the prospective resident;
  2. The mental health, emotional, and psychological needs of the prospective resident;
  3. The physical health needs, including the immunization needs, of the prospective resident;
  4. The protection needs of the prospective resident;
  5. The suitability of the prospective resident's admission;
  6. The behavior support needs of the prospective resident;
  7. Family history and relationships;
  8. Social and development history;
  9. Current behavioral functioning and social competence;
  10. History of previous treatment for mental health, mental retardation, substance abuse, brain injury, and behavior problems; and
  11. Medication and drug use profile.
- Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 1. The needs of the prospective resident can be addressed by the facility's services;
  2. The facility's staff are trained to meet the prospective resident's needs; and
  3. The admission of the prospective resident would not pose any significant risk to (i) the prospective resident or (ii) the facility's residents or staff.

12VAC35-46-750. (Children Residential Regulations)

- An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter.
- Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident;
  2. Resident's current level of functioning;
  3. Goals, objectives, and strategies established for the resident;
  4. Projected family involvement;
  5. Projected date for accomplishing each objective; and 6. Status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges only upon receipt of the

				order of a court of competent jurisdiction. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	24-hour staff	Provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis
		Staff Credentials	• Licensed or credentialed clinical staff (addiction counselors, social workers, and licensed professional counselors) who work with the allied health professional staff in an interdisciplinary team approach. • Allied health professional staff, such as counselor aides or group living workers who are on-site 24/7, or as required by licensing standards. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day. • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUDs and their treatment and who are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation	12 VAC35-105-1080. • The provider shall document staff training in the areas of: 1. Management of withdrawal; and 2. First responder training. • Untrained employees or contractors shall not be solely responsible for the care of individuals. 12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time. 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures that address the provision of: 1. Psychiatric care; 2. Family therapy; and 3. Staffing appropriate to the needs and behaviors of the residents served. 12VAC35-46-370 (Children Residential Regulations) • Child care supervisors shall have responsibility for the: 1. Development of the daily living program within each child care unit; and 2. Orientation, training, and supervision of direct care workers. 12VAC35-46-380. (Children Residential Regulations) • The child care worker shall have responsibility for guidance and supervision of the children. 12VAC35-46-390. (Children Residential Regulations)

				• Qualified relief staff shall be employed as necessary to meet the needs of the programs and services offered and to maintain a structured program of care 12VAC35-46-350. (Children Residential Regulations) • Program Director-The facility's program shall be directed by one or more qualified persons. • Persons directing programs shall be responsible for the development and implementation of the programs and services offered by the facility, including overseeing assessments, service planning, staff scheduling, and supervision. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	Telephone or in-person consultation with a physician and emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call

				or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services 12VAC35-46-820. (Children Residential Regulations) • The provider shall develop and implement written policies and procedures for a crisis or clinical emergency that shall include: 1. Procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if on-call physician back-up or mental health clinical services are not available; and 2. Employee or contractor responsibilities.
		Purpose of Treatment	• Services are for individuals whose addiction is so out of control that they need a 24-hour supportive treatment environment. • The treatment community is a therapeutic agent.	Services to eliminate or reduce the effects of alcohol or other drugs in the individual's body. Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders). 12VAC35-46-10 (Children Residential Regulations) • Designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment.
		Schedule-Clinical Services	Daily	24-hour support in conjunction with care and treatment or a training program. 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. B. Each provider shall have formal arrangements for the evaluation, assessment, and treatment of the mental health or brain injury needs of the resident.

		Types Clinical Services	Treatment is characterized by services such as individual, group and family therapy using a range of evidence-based practices; medical and nursing; physical therapy; medication management; and psychoeducation	Intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders in a residential setting, other than an inpatient service. 12VAC35-46-625. (Children's Residential Regulations) • Interventions, applicable to the population served, shall include, but are not limited to: 1. Individual counseling; 2. Group counseling; 3. Training in decision making, family and interpersonal skills, problem solving, self-care, social, and independent living skills; 4. Training in functional skills; 5. Assistance with activities of daily living (ADL's); 6. Social skills training in therapeutic recreational activities, e.g., anger management, leisure skills education and development, and community integration; 7. Providing positive behavior supports; 8. Physical, occupational, and/or speech therapy; 9. Substance abuse education and counseling; and 10. Neurobehavioral services for individuals with brain injury.
		Services	• Biopsychosocial assessment • Individualized treatment planning • Clinically directed treatment • Addiction pharmacotherapy • Random drug screening • Motivational enhancement and engagement strategies • Occupational or recreational activities • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Planned community reinforcement to foster community living skills • Recovery support services • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder • Self-help meetings are available on-site, or easily accessible in the local community	Intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders. 12VAC35-46-10 (Children Residential Regulations) • Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child.
		Support Systems	• Direct affiliations with other levels of care, or close coordination through referral to more and less intensive services (such as IOP, vocational, literacy training and adult education) • Ability to arrange for needed procedures, including laboratory and toxicology tests • Medical, psychiatric, psychological services available through consultation or referral.	12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The

				timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; 12VAC35-46-750. (Children Residential Regulations) The initial individualized service plan shall be reviewed within 60 days of the initial plan and within each 90-day period thereafter and revised as necessary. 12VAC35-46-360. Case managers shall have the responsibility for coordination of all services offered to each resident. Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

DBHDS Licensing and ASAM LOC Crosswalk

ASAM LOC	DBHDS LICENSE	CARE COMPONENT	ASAM REQUIREMENTS	DBHDS REQUIREMENTS
3.7 Medically Monitored Intensive Inpatient Services	• Psychiatric Unit within an acute care general hospital – with a detox license • Acute/freestanding psychiatric hospital –with a Medical Detox license; Substance Abuse Residential Treatment Services for Adults or Children with a detox license; Residential Crisis Stabilization Units with a detox license	Setting	24 hour professionally-directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting.	**Psychiatric Unit within an acute care general hospital** "Special care unit" means an appropriately equipped area of the hospital where there is a concentration of physicians, nurses, and others who have special skills and experience to provide optimal medical care for patients assigned to the unit. (12VAC5-410-10) **Acute psychiatric hospital** "Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric, maternity). (12VAC5-410-10) **Psychiatric unit within an acute care general hospital or Acute psychiatric hospital –** An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20) **"Medical detoxification"** means a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body. **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and **substance abuse residential treatment for women and children.** **"Children's residential facility" or "facility"** means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia
		Service Delivery Examples	Freestanding, appropriately licensed facility located within a the context of an acute care hospital or acute psychiatric unit of a freestanding Level 3.5 residential facility	Free standing psychiatric or substance abuse hospital, or an acute care facility with a specialized psychiatric or substance use treatment unit. An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20) In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility.
		Admission Criteria	Patient meets specifications in at least **two** of the six dimensions, at least **one** of which is in Dimension 1, 2, or 3: 1. Patient needs withdrawal management protocol 2. Interaction of the patient's biomedical condition and	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served.

			continued alcohol and/or other drug use places the patient at significant risk of serious damage to physical health or concomitant biomedical conditions; **OR** a current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital. 3. If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the patient does not accept or relate the addictive disorder to the severity of the presenting problem; **OR** patient is in need of intensive motivating strategies, activities, and processed available only in a 24-hour structured, medically monitored setting; **OR** ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program. 5. Patient is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder, which poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support; **OR** patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support found in a medically monitored setting; **OR** the intensity or modality of treatment protocols to address relapse require that the patient receive Level 3.7 program, to safely and effectively initiate antagonist therapy, or agonist therapy. 6. Patient requires continuous medical monitoring while addressing his or her substance use and/or psychiatric symptoms because his or her current living situation is characterized by a high risk or initiation or repetition or physical, sexual, or emotional abuse, or active substance abuse, such that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; **OR** family members or significant others living with the patient are not supportive of his or her recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts; **OR** patient is unable to cope, for even limited periods of time, outside of 24-hour care.	• The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. 12VAC35-46-640. (Children's Residential Regulations) • The facility shall have written criteria for admission that shall include: 1. A description of the population to be served; 2. A description of the types of services offered; 3. Intake and admission procedures; 4. Exclusion criteria to define those behaviors or problems that the facility does not have the staff with experience or training to manage; and 5. Description of how educational services will be provided to the population being served. • The facility shall accept and serve only those children whose needs are compatible with the services provided through the facility unless a child's admission is ordered by a court of competent jurisdiction. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. o Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care meet diagnostic	**Psychiatric unit within a general hospital and acute psychiatric hospital**

			criteria for moderate or severe SUD • Patients have functional limitations in one of the following areas: acute intoxication and/or withdrawal potential, biomedical conditions and complications; or emotional, behavioral, or cognitive conditions and complications **AND** functional limitations in at least one other dimension.	An initial individualized services plan (ISP) shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs. (12VAC35-105-660 B) A physical examination shall be administered within 24 hours of an individual's admission. The physical examination shall include, at minimum: • General physical condition (history and physical); • Evaluation of communicable diseases; • Recommendations for further diagnostic tests and treatment, if appropriate; • Other examinations that may be indicated; and • The date of examination and signature of a qualified practitioner (12VAC-35-105-740) In addition, for individuals treated for managed withdrawal, providers shall: • Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others: • Assess substances used an time of last use; • Determine time of last meal; • Administer a urine screen; • Analyze blood alcohol content or administer a breathalyzer; and • Record vital signs (12VAC35-105-1110) Unless the individual refuses, the provider shall take vital signs; • At admission and discharge; • Every four hours for the first 24 hours and every with hours thereafter; and • As frequently as necessary, until signs and symptoms stabilize for individuals with a high-profile. (12VAC35-105-1120) 12VAC35-105-645 E. An assessment shall be initiated prior to or at admission to the services. An initial assessment shall determine whether the individual qualifies for admission and at minimum shall include the individual's: • Diagnosis; • Presenting needs; • Current medical problems; • Current medications; Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and • At risk behaviors to self and others. 12VAC35-105-650. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems;

				3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-46-10 (Children Residential Regulations) The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. 12VAC35-46-630. (Children Residential Regulations) • Acceptance of children. Children shall be accepted only by court order or by written placement agreement with legal guardians. • 12VAC35-46-710. (Children Residential Regulations) • Admission shall be based on evaluation of an application for admission. The requirements of this section do not apply to court-ordered placements or transfer of a resident between residential facilities located in Virginia and operated by the same sponsor. • Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 1. The educational needs of the prospective resident; 2. The mental health, emotional, and psychological needs of the prospective resident; 3. The physical health needs, including the immunization needs, of the prospective resident; 4. The protection needs of the prospective resident; 5. The suitability of the prospective resident's admission; 6. The behavior support needs of the prospective resident; 7. Family history and relationships; 8. Social and development history; 9. Current behavioral functioning and social competence; 10. History of previous treatment for mental health, mental retardation, substance abuse, brain injury, and behavior problems; and 11. Medication and drug use profile. • Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 1. The needs of the prospective resident can be addressed by the facility's services; 2. The facility's staff are trained to meet the prospective resident's needs; and 3. The admission of the prospective resident would not pose any significant risk to (i) the prospective resident or (ii) the facility's residents or staff. 12VAC35-46-750. (Children Residential Regulations) • An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter. • Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident; 2. Resident's current level of functioning; 3. Goals, objectives, and strategies established for the resident;

				4. Projected family involvement; 5. Projected date for accomplishing each objective; and 6. Status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges only upon receipt of the order of a court of competent jurisdiction. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	24-hour	24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.
		Staff Credentials	• An interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists), who are able to assess and treat the patient and to obtain and interpret information regarding the patient's psychiatric and substance use disorder. • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders, and with specialized training in behavior management techniques and evidence-based practices. • A licensed physician to oversee the treatment process and assure the quality of care. Physicians perform physical examinations for al patients admitted to this level or care.	As above and the psychiatric service shall be under the supervision of a physician, licensed by the Board of Medicine, who meets the qualifications of the medical staff bylaws. Medical, nursing, and treatment services (12VAC35-105-20) The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: • Needs of the individuals served; • Types of services offered; • The service description; and • Number of people to be served at a given time. (12VAC35-105-590 A) Supervision of staff shall be provided by a licensed mental health professional or mental health professional who is license-eligible and registered with a board of the Department of Health Professions. (12VAC35-105-590 C.5) 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures that address the provision of: 1. Psychiatric care; 2. Family therapy; and 3. Staffing appropriate to the needs and behaviors of the residents served.

				12VAC35-46-370 (Children Residential Regulations) Child care supervisors shall have responsibility for the: 1. Development of the daily living program within each child care unit; and 2. Orientation, training, and supervision of direct care workers. 12VAC35-46-380. (Children Residential Regulations) The child care worker shall have responsibility for guidance and supervision of the children. 12VAC35-46-390. (Children Residential Regulations) • Qualified relief staff shall be employed as necessary to meet the needs of the programs and services offered and to maintain a structured program of care 12VAC35-46-350. (Children Residential Regulations) • Program Director-The facility's program shall be directed by one or more qualified persons. • Persons directing programs shall be responsible for the development and implementation of the programs and services offered by the facility, including overseeing assessments, service planning, staff scheduling, and supervision. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or

				master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	In-person assessment within 24-hours of admission and thereafter as medically necessary.	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services 12 VAC35-105-1090. In detoxification service locations, at least two employees or contractors shall be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available. In other managed withdrawal settings the number of staff on duty shall be appropriate for the services offered and individuals served. 12VAC35-46-820. (Children Residential Regulations) • The provider shall develop and implement written policies and procedures for a crisis or clinical emergency that shall include: 1. Procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if on-call physician back-up or mental health clinical services are not available; and 2. Employee or contractor responsibilities.
		Purpose of Treatment	Services are provided to patient whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment	The provider shall develop a written mission statement that clearly identifies its philosophy, purpose, and goals. (12VAC35-105-570) Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).

				To systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.
		Schedule-Clinical Services	Daily	Intensive 24-hour medical, nursing, and treatment service 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. B. Each provider shall have formal arrangements for the evaluation, assessment, and treatment of the mental health or brain injury needs of the resident.
		Types Clinical Services	Treatment is characterized by services such as individual, group and family therapy using a range of evidence-based practices; medical and nursing management of any acute symptoms; physical therapy; medication management; and psychoeducation	24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body. 2VAC35-105-1055. • In the service description the provider shall describe the level of services and the medical management provided. 12VAC35-46-625. (Children's Residential Regulations) • Interventions, applicable to the population served, shall include, but are not limited to: 1. Individual counseling; 2. Group counseling; 3. Training in decision making, family and interpersonal skills, problem solving, self-care, social, and independent living skills; 4. Training in functional skills; 5. Assistance with activities of daily living (ADL's); 6. Social skills training in therapeutic recreational activities, e.g., anger management, leisure skills education and development, and community integration; 7. Providing positive behavior supports; 8. Physical, occupational, and/or speech therapy; 9. Substance abuse education and counseling; and 10. Neurobehavioral services for individuals with brain injury. Not further specified in licensure requirements
		Services	• Biopsychosocial assessment • Individualized treatment planning • Clinically directed treatment • Psychiatric stabilization • Addiction pharmacotherapy • Random drug screening • Motivational enhancement and engagement strategies • Health education • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Recovery support services • Services for the patient's family and significant others, as	The provider shall prepare a written description of each service it offers. Elements of each service description shall include: • Service goals; • A description of care, treatment, or other supports provided; • Characteristics and needs of individuals to be served; • Contract services, if any; • Eligibility requirements and admission, continued stay, and exclusion criteria; • Service termination and discharge or transition criteria; and • Type and role of employees or contractors. (12VAC35-105-580 C1 – C7) The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse

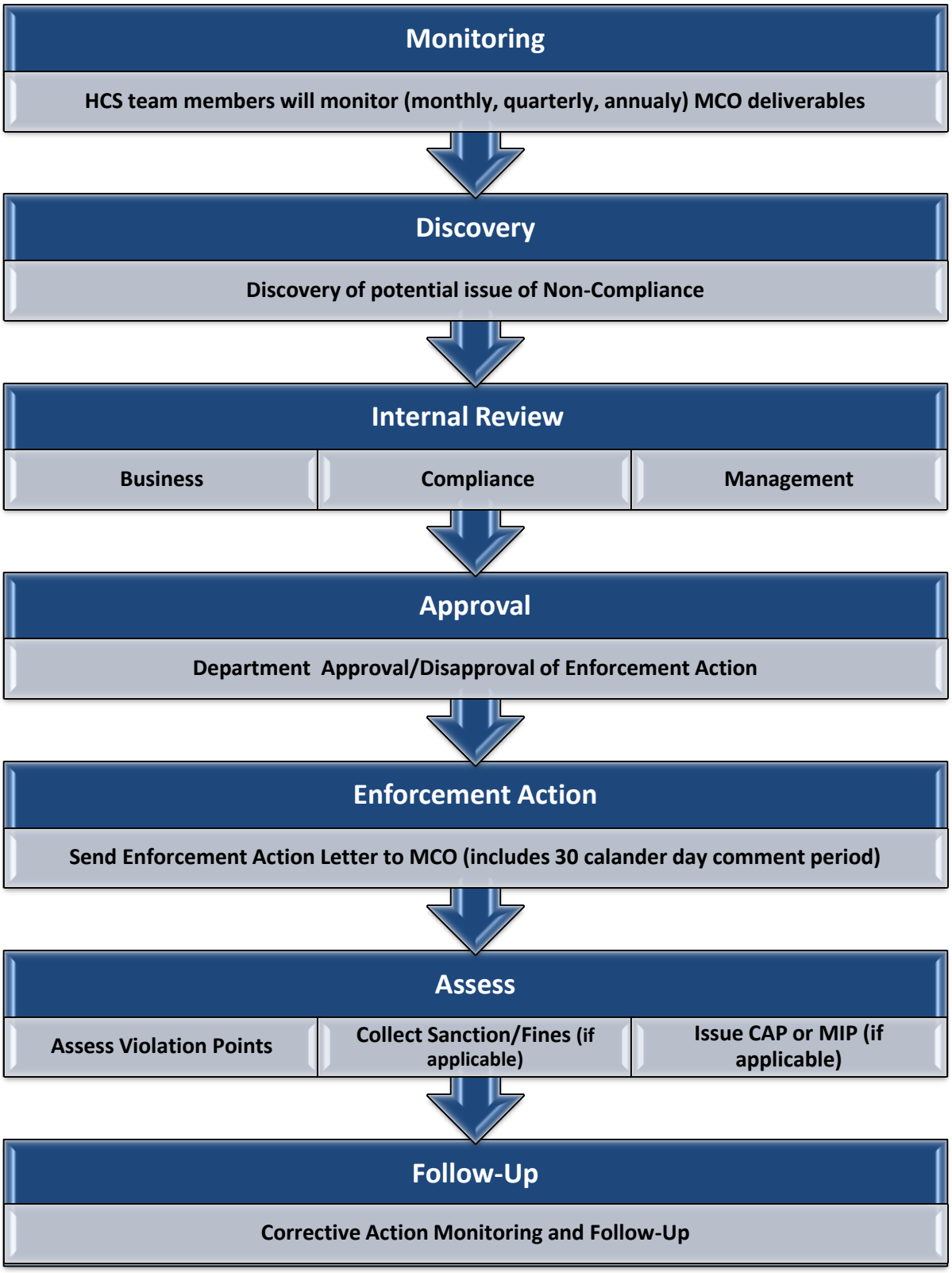
			appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder	(substance use disorders). (12VAC-35-105-580 H.) 12VAC35-46-10 (Children Residential Regulations) Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child.
		Support Systems	• A registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission. • Additional medical specialty consultation, psychological, laboratory, and toxicology services are available on-site, through consultation or referral. • Coordination of necessary services or other levels of care are available through direct affiliation or referral processes. • Psychiatric services are available on-site, through consultation or referral. Serves are to be available within 8 hours by telephone or 24 hours in person.	12VAC35-105-1055. • In the service description, the provider shall describe the level of services and the medical management provided. 12VAC35-105-1060. The provider shall establish cooperative agreements with other community agencies to accept referrals for treatment, including provisions for physician coverage if not provided on-site, and emergency medical care. The agreements shall clearly outline the responsibility of each party. 12VAC35-105-720. • Providers of residential or inpatient services shall provide or arrange for the provision of appropriate medical care. Providers of other services shall define instances when they shall provide or arrange for appropriate medical and dental care and instances when they shall refer the individual to appropriate medical care. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses;

				4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
4.0 Medically Managed Intensive Inpatient Services	Acute care general hospital - 12-VAC5-410	Setting	• Acute care medical facility • Medically-directed care • 24-hour treatment • Offers addition treatment services along with intensive biomedical and/or psychiatric services • **Must offer medically direct acute withdrawal management, emergency life support care and treatment** – either directly or through transfer of patient to another service within the facility, or to another medical facility equipped to provide such care.	Hospitals to be licensed shall be classified as general hospitals, special hospitals or outpatient hospitals defined by 12VAC5-410-10.
		Service Delivery Examples	• Acute care general hospital • Acute psychiatric hospital • Psychiatric unit within an acute care general hospital	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Admission Criteria	Patient meets specifications in at least **one** Dimensions 1, 2, or 3: 1. Patient needs withdrawal management 2. Biomedical complications of the addictive disorder require medical management and skilled nursing care; **OR** a concurrent biomedical illness or pregnancy requires stabilization and daily medical management with daily primary nursing interventions; **OR** patient has a concurrent biomedical condition(s) in which continued alcohol or other drug use presents an imminent danger to the life or severe danger to health; **OR** patient is experiencing recurrent or multiple seizures; **OR** patient is experiencing a disulfiram-alcohol reaction; **OR** patient has life-threatening symptoms that are related to use of alcohol, tobacco, and/or other drugs; **OR** changes in the patient's medical status, such as	**Acute care general hospital** - Not specified in DBHDS licensure requirements

			significant worsening of a medical condition, make abstinence imperative; **OR** significant improvement in a previously unstable medical condition allows the patient to respond to addiction treatment; **OR** patient has (an)other biomedical problem(s) that requires 24-hour observation and evaluation. 3. Patient whose status is characterized by stabilized emotional, behavioral, or cognitive condition is appropriately assessed as in need of Level 4 co-occurring capable program services; **OR** if the patient's emotional, behavioral, or cognitive conditions symptoms are so severe as to require admission to a Level 4 program, then only a co-occurring enhanced program is sufficient to meet the patient's needs. 4. Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program. 5. Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program. 6. Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program.	
		Admission Process	• Meet diagnostic criteria for a SUD • Patients have functional limitations in one of the following areas: acute intoxication and/or withdrawal potential, biomedical conditions and complications; or emotional, behavioral, or cognitive conditions and complications	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Staffing	• 24-hour	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Staff Credentials	• An interdisciplinary staff of appropriately credential clinical staff (including addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers), who assess and treat patients with severe substance use disorders, or addicted patients with concomitant acute biomedical, emotional, or behavioral disorders. Facility approved addition counselors or licensed, certified, or registered addiction clinicians who administer planned interventions according to the assessed needs of the patient.	**Acute general hospital** An organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and treatment for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity. (12VAC5-410-10)
		Physician Coverage	• In-person 24 hours a day, and professional consultation 16 hours a day	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Purpose of Treatment	• Services are provided to patients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care.	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Schedule-Clinical Services	• Individualized • 24-hours	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Types Clinical Services	• Individualized array of treatment services for SUDs, as well as any concurrent biomedical, emotional, behavioral, or cognitive problems delivered by an interdisciplinary team	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Services	• Biopsychosocial assessment • Individualized treatment planning • Biomedical treatment • Psychiatric stabilization and treatment • Addiction pharmacotherapy	**Acute care general hospital** - Not specified in licensure requirements

			• Motivational enhancement and engagement strategies • Health education • Individualized treatment activities to monitor mental health, and to address the interaction of the mental health problems and SUD • Regular monitoring of patient's medication adherence • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder	
		Support Systems	• A full range of acute care services, specialty consultation, and intensive care.	**Acute care general hospital** - Not specified in DBHDS licensure requirements

Contract Compliance Enforcement Process



Department of Behavioral Health Developmental Services
Office of Recovery Services

Scope of Practice for Certified Peer Recovery Specialists

Certified Peer Recovery Specialists (CPRS) provide non-clinical, person-centered, strengths based, wellness focused, and trauma-informed support while helping to ensure the person's wellness-recovery plan reveals the needs and preferences of the person being served to complete their measurable and personalized goals. CPRSs serve adults with behavioral health challenges. Certified Peer Recovery Specialists also serve parent peers and family members who provide support to parents and children who experience behavioral health challenges.

The type and intensity of services provided must be determined on an individual basis, taking into account the acuity of the situation for the person(s) receiving services, as well as the experience of the CPRS. The foundational value that Certified Peer Recovery Specialists support is always received on a voluntary basis and must be the foundation of all relationships. CPRSs share their first-hand experiences that inspire and support individuals in their responses, choices and management of behavioral challenges. They assist people in expressing and achieving personal goals for wellness, recovery, resiliency and self-advocacy. CPRSs provide and advocate for effective recovery and wellness oriented services.

Certified Peer Recovery Specialists:

1) ***Provide face to face interaction that supports an individual achieving their self-identified level of recovery, wellness, independence or personal strength.***

   a. Serve as a role model for recovery and wellness and self-advocacy. Provide feedback and insight into the value of every individual's unique recovery experience.
   b. Assist an individual or family receiving services with writing and communicating their personal recovery-wellness plans and to identify ways to reach those goals using a person-centered, individual recovery-wellness plan.
   c. Increase the individual's resiliency by assisting them in recognizing and augmenting personal strengths in skill areas related to handling problems encountered in daily life; such as self-awareness, resource discovery, and self-responsibility. Assist in gaining/regaining control of their lives through recovery and/or wellness based activities, concepts, and understandings.
   d. Share effective and positive strategies for developing coping skills and wellness tools related to overcoming the effects of having a trauma, a substance use disorder, or a mental health challenge.
   e. Clarify and enhance self-advocacy skills. Encourage peers to develop independent behavior that is based on informed choice; assisting peers in developing empowerment skills through self-advocacy.
   f. Establish and maintain a peer relationship based on mutuality rather than a hierarchical relationship. Partner with the other person to facilitate recovery dialogues and other evidence-based and/or best practice methods
   g. Assist peers in selecting behavioral health services that suit each person's individual recovery and wellness needs; Inform peers about community based and natural supports and how to utilize these in the recovery process.
   h. Provide education on wellness and/or recovery
   i. Assist in developing a psychiatric advance directive
   j. Assist individuals and families of children in creating crisis recovery response plans.
   k. Accompany people through the behavioral health service intake process and the discharge process, with person to person, face-to-face follow up after discharge of person. Help people identify and implement service exit strategies.
   l. Provide outreach to people who have frequent inpatient experiences. Provide outreach to people who have failed to engage with the behavioral health system.

2) Provide trained peer-to-peer support in groups encouraging and supporting participation and self-directed participation.

a. Serve as a role model for recovery and wellness and self-advocacy. Provide feedback and insight into the value of every individual's unique recovery experience.
b. Assist in developing skills needed to identify a variety of groups that may be helpful and available in the community.
c. Facilitate peer-to -peer evidence-based practices or best practices, such as WRAP, Dual Recovery, 12-Step groups, WHAM, High Fidelity Wraparound, etc.
d. Facilitate non-clinical peer to peer recovery education and wellness coaching through group activities in topics such as stress management, healthy leisure activities, wellness, alternative treatment options, recovery, focusing on individual health and wellness strengths and needs, self-affirmation, treatment management techniques, community involvement strategies, etc.
e. Increase the individual's resiliency by assisting them in recognizing and augmenting personal strengths in skill areas related to handling problems encountered in daily life; such as self-awareness, resource discovery, and self-responsibility. Assist in gaining/regaining control of their lives through recovery and/or wellness based activities, concepts, and understandings.
f. Share effective and positive strategies for developing coping skills and wellness tools related to overcoming the effects of having a trauma, a substance use disorder, or a mental health challenge.
g. Clarify and enhance self-advocacy skills. Encourage peers to develop independent behavior that is based on informed choice; assisting peers in developing empowerment skills through self-advocacy.
h. Establish and maintain a peer relationship based on mutuality rather than a hierarchical relationship. Partner with the other person to facilitate recovery dialogues and other evidence-based and/or best practice methods.
i. Assist peers in selecting behavioral health services that suit each person's individual recovery and wellness needs; Inform peers about community based and natural supports and how to utilize these in the recovery process.
j. Provide education on wellness and/or recovery.
k. Assist in developing a psychiatric advance directive.
l. Assist individuals and families of children in creating crisis recovery response plans.
m. Accompany people through the behavioral health service intake process and the discharge process, with person to person face to face follow up after discharge of person. Help people identify and implement service exit strategies.
n. Provide outreach to people who have frequent inpatient experiences. Provide outreach to people who have failed to engage with the behavioral health system.

3) Mentor community integration activities (one-to-one or in groups)

a. Provide community networking and linkage with social, recreational, spiritual, volunteer, educational or vocational resources. Assist the person in identifying traditional and non-traditional community based supports that sustain a healthy life style. Provide opportunities to practice socialization, interaction and engagement abilities in the community. Support, encourage, and enhance the development of natural support systems and independent choice and participation.
b. Assist in the development of a community integration plan that sets milestones for an increased independent community involvement, showing a decrease of dependency on the CPRS
c. Support for day-to-day problem solving related to integration/reintegration into the positive community of choice.

d. Enhance the person's/family's ability to navigate the systems of service delivery related to the person's written wellness-recovery plan or individual service plan. Provide, when available, time-limited transportation focusing on increasing the individual's transportation independence through access to natural or formal resources.
e. Assist other behavioral healthcare service providers in identifying program and service environments that are conducive to recovery.

4) Provide emotional support during the acquisition, exploration and sustaining of employment and/or educational services.

a. Support the vocational and educational choices of peers and assist them in developing strategies for overcoming educational or job-related behavioral health challenges that lead to independence.

5) Attend treatment team and program development meetings.

a. Promote the use of self-directed recovery and wellness tools in individualized treatment planning. Facilitate the inclusion of the person being served in all meetings that relate to the delivery of services. Promote the inclusion of the individual in all treatment plans related to their healthcare.
b. The CPRS will share his or her unique perspective on recovery from mental illness or substance use disorder with non-peer staff. Assist non-peer staff in identifying programs and environments that are advantageous to supporting recovery and wellness outcomes.

COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

May 10, 2016

Dear Colleague,

There is an opioid overdose crisis in the United States. In 2014 there were 18,893 prescription drug overdose deaths and 10,574 heroin deaths, and there is broad agreement that a key ingredient to solving this problem is proper prescribing for pain management.

Accordingly, in March 2016 the Center for Disease Control released the Guideline for Prescribing Opioids for Chronic Pain. This guideline, which is summarized below, addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. The CDC has a number of related resources, such as a 2-page summary, a prescribing checklist and recommended non-opioid treatments, on their website. If you are a prescriber of opioids, I ask you to please review the full guideline, which contains background, documentation and rationale for the following recommendations:

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

2. Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.

4. When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement

additional precautions when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to ≥90 MME/ day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days usually will be sufficient for most nontraumatic pain not related to major surgery.

7. Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids.

8. Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, or higher opioid dosages (≥50 MME), are present.

9. Providers should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, providers should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.

12. Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

These recommendations are aligned with initiatives that we are implementing as a result of the Governor's Task Force on Prescription Drug and Heroin Abuse. Prescribers are now automatically registered with Virginia's Prescription Monitoring Program, and starting July 1 will be required to check the PMP for most prescriptions lasting more than 14 days. The

Board of Medicine is now allowed to require CME in opiate-related areas (beginning with 2018 renewals), and is convening a workgroup on buprenorphine.

Thank you for your attention to this critical issue. Together we will find ways to effectively manage our patients' pain while also preventing addiction, misuse and overdose.

Sincerely,

William A. Hazel Jr., M.D.

Uniform SA Request Form for Initiation of Subutex (Buprenorphine SL) or Suboxone® (Buprenorphone/Naloxone) Sublingual Film

I. GUIDELINES:

1. ***Coverage Policy*:** Suboxone® and buprenorphine will be covered for the treatment of Opioid Use Disorder when all of the following conditions are met:
    a. Individual has a diagnosis of Opioid Use Disorder AND
    b. Individual is 16 years of age or older AND
    c. Prescriber's personal DEA and X DEA Number are provided AND
    d. Individual is participating in psychosocial counseling (individual or group) at least once per week during first 3 months of initiation.
2. ***Induction:*** A one-time 7-day quantity of Suboxone® (or buprenorphine if a member is pregnant or transitioning from methadone) will be allowed without a SA.
3. ***Buprenorphine:*** Buprenorphine monotherapy will only be covered for pregnant women for a maximum of 9 months. Date of positive pregnancy test must be provided.
4. ***Initial Authorization:*** Initial request will be authorized for 3 months. Additional service authorizations will not be required for dose adjustments. After 3 months, the provider must submit the SA Request Form for Buprenorphine or Suboxone® Maintenance.
5. ***Dose Maximum:*** Maximum of 16 mg per day will be covered unless compelling clinical rationale for exceeding this dose with written documentation is provided. Dose greater than 24 mg per day will not be approved.
6. ***Lock In Policy***: Upon approval, the patient will be automatically locked in for buprenorphine or Suboxone® to the requesting physician and to the dispensing pharmacy.
7. ***Concurrent Medications:***
    a. The following medications will NOT be allowed to be prescribed or taken concurrently: tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants.
    b. Benzodiazepines will only be allowed for first three months of Suboxone®. The same provider must prescribe the benzodiazepines and the Suboxone®. Prescriber must counsel patient on higher risk of fatal overdose. Maximum daily dose equivalent of clonazepam (Klonopin) 2 mg will be allowed. Patient must be weaned off benzodiazepines to other anti-anxiety medications (such as SSRIs, buspirone, or clonidine) by 3 months in order to receive approval of buprenorphine or Suboxone® for maintenance.
8. ***Reasons for Non-Coverage:***
    a. Requests for any diagnosis other than Opioid Use Disorder.
    b. Concurrent use of other opiates, stimulants, carisoprodol (Soma), or tramadol (Ultram).
    c. Lack of participation in psychosocial counseling at least once per week.

II. PHYSICIAN INFORMATION

1. Name and Address, NPI Number
2. Physician DEA Number
3. Physician DATA waiver ID number (X DEA Number)

III. PATIENT INFORMATION

1. Name, Address, ID#, DOB, Gender, Phone Number, Date of Rx
2. Is patient 16 years of age or greater? Yes or No
3. Does patient meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf)? Yes or No
4. List any medical conditions patient has that could impact recovery or choice of medication (such as mental illness, seizure disorder, etc.)
5. Does patient have HIV, Hepatitis B, or Hepatitis C?
6. Is the patient pregnant? If yes, provide date of positive pregnancy test.

IV. TREATMENT INFORMATION

1. Suboxone® or Buprenorphine SL Dose, Directions, and Quantity
2. If requesting dose of greater than 16 mg per day, provide clinical rationale including documentation of why this higher dose is medically necessary for patient.
3. Can you confirm that the patient is NOT prescribed or taking any of the following medications: tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants? Yes or No
4. Is patient taking a benzodiazepine? Yes or No
5. If yes, provide written documentation that the patient was counseled on higher risk of fatal overdose and provide plan for weaning patient off benzodiazepines to other anti-anxiety medications (such as SSRIs, buspirone, or clonidine) by 3 months. Maximum daily dose equivalent of clonazepam (Klonopin) 2 mg will be allowed.
6. Is patient receiving psychosocial counseling (individual or group) at least once per week? Yes or No*
7. Provide name and phone number of counselor.

If provider answers no to any questions in red → request will not be approved

*Note: Health plans and Magellan may review claims data to confirm that patient is receiving counseling. If provider is not billing for counseling, provide the most recent counseling note.

Uniform SA Request Form for Maintenance of Subutex (Buprenorphine SL) or Suboxone® (Buprenorphone/Naloxone) Sublingual Film

GUIDELINES:

1. ***Coverage Policy*:** Suboxone® and buprenorphine will be covered for the treatment of Opioid Use Disorder when all of the following conditions are met:
    - Individual has a diagnosis of Opioid Use Disorder AND
    - Individual is 16 years of age or older AND
    - Prescriber's personal DEA and X DEA Number are provided AND
    - Individual is participating in psychosocial counseling (individual or group) at least once per month during maintenance.
2. ***Buprenorphine:*** Buprenorphine monotherapy will only be covered for pregnant women for a maximum of 9 months and date of positive pregnancy test must be provided.
3. ***Initial Authorization:*** Initial request will be authorized for 3 months.
4. ***Renewal Authorizations for Maintenance***: The second and subsequent requests will be authorized for 6 months. Additional service authorizations will not be required for dose adjustments. Before approving the maintenance request, the health plan will:
    - Verify continued participation in psychosocial counseling using claims data.
    - Review documentation from provider that urine drug screens confirm no concurrent opioids and patient is taking buprenorphine.
5. ***Dose Maximum:*** Maximum of 16 mg per day will be covered unless compelling clinical rationale for exceeding this dose with written documentation is provided. Dose greater than 24 mg per day will not be approved.
6. ***Duration:*** There is no set time limit or maximum duration of treatment. Risk of relapse related to treatment discontinuation should be weighed against the risk of continued medication use on an individual patient basis. Duration of treatment should be individualized to meet the patient's needs. There is evidence that longer treatment duration is associated with decreased risk of relapse. Discontinuation should be a mutual discussion between the physician and patient, after the treatment goals are reached. If the physician and patient decide to discontinue treatment, the daily dose should be decreased gradually over a predetermined period at a rate determined by the patient and physician together.
7. ***Concurrent Medications:***
    - The following medications will NOT be allowed to be prescribed or taken concurrently: benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants.
8. ***Reasons for Non-Coverage:***
    - Requests for any diagnosis other than Opioid Use Disorder.
    - Concurrent use of other opiates, stimulants, benzodiazepines, carisoprodol (Soma), or tramadol (Ultram).
    - Lack of participation in psychosocial counseling at least once per month.
    - Required documentation of urine drug screens is not provided.
    - Urine drug screen is negative for buprenorphine/norbuprenorphine or positive for another substance and documentation of steps being taken to address possible diversion of Suboxone® and/or ongoing use of other substances is not provided.
    - Provider has not checked the PMP on the date of the request

    .

I. PHYSICIAN INFORMATION

1. Name and Address, NPI Number
2. Physician DEA Number
3. Physician DATA waiver ID number (X DEA Number)

II. PATIENT INFORMATION

1. Name, Address, ID#, DOB, Gender, Phone Number, Date of Rx
2. Is patient 16 years of age or greater? Yes or No
3. Does patient meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf)? Yes or No
4. List any medical conditions patient has that could impact recovery or choice of medication (such as mental illness, seizure disorder, etc.)
5. Does patient have HIV, Hepatitis B, or Hepatitis C?
6. Is patient pregnant? If yes, provide date of positive pregnancy test.

III. TREATMENT INFORMATION

1. Buprenorphine/naloxone or Buprenorphine Dose, Directions, and Quantity
2. Can you confirm that the patient is NOT taking any of the following medications: benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants? Yes or No
3. Is this patient receiving psychosocial counseling (individual or group) at least once per month? Yes or No*
4. Provide name and phone number of counselor.

IV. MONITORING

1. Is prescriber checking random urine drug screens at least 4 times per 6 months? Yes or No
2. Do the urine drug screens check for buprenorphine/norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates? Yes or No
3. Provide last 2 urine drug screens (with at least 1 of these screenings within past month). **Copies must be provided for approval.**
4. Are 2 urine drug screens attached? Yes or No
5. Is the date of at least one of these screens within the past month? Yes or No
6. Are all urine drug screens positive for buprenorphine/norburpenorphine? Yes or No
7. Are all urine drug screens negative for all other substances? Yes or No
8. If a drug screen is negative for buprenorphine/norbuprenorphine and/or positive for another substance, provide written documentation of steps being taken to address patient's possible diversion of buprenorphine and/or ongoing use of other substances including intensifying the counseling that patient is receiving and/or considering referral to higher level of care (such as intensive outpatient, partial hospitalization, or residential treatment).
9. Has the prescriber reviewed the Virginia Prescription Monitoring Program on the date of this request? Yes or No

If provider answers no to any questions in red → request will not be approved

*Note: Health plans and Magellan may review claims data to confirm that patient is receiving counseling. If provider is not billing for counseling, provide the most recent counseling note.

VCU Health
VCU School of Medicine

Health Behavior and Policy
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Richmond, VA 23298-0149

Proposed VCU Independent Evaluation of Virginia Medicaid SUD Benefit and Waiver Required by CMS (May 12, 2016)

Background

The Commonwealth of Virginia is transforming the delivery system for Medicaid members with Substance Use Disorders (SUD). The new Medicaid SUD Treatment Benefit positions the Commonwealth to apply to CMS for a Medicaid Section 1115 waiver. The SUD waiver will require an evaluation of the effectiveness of the services delivered in terms of clinician SUD training and service provision as well as Medicaid member health outcomes, health care costs, and service utilization. To that end, a team of researchers from the Virginia Commonwealth University School of Medicine is proposing to conduct a robust evaluation of the new SUD benefit and waiver.

Evaluation Aims

The evaluation has the following aims:

1. How do the new SUD benefit and waiver affect clinician SUD training and SUD service provision?
   a) To what extent are efforts to prepare and train health care clinicians successful in getting them to appropriately provide SUD benefits?
   b) How do the new SUD benefit and waiver affect the number and type of health care clinicians providing SUD services to Medicaid members with SUD?
2. How do the new SUD benefit and waiver affect members' access to and utilization of SUD services?
   a) To what extent do the new SUD benefit and waiver increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering SUD treatment services to Medicaid members?
   b) How do the new SUD benefit and waiver affect the type and quantity of SUD treatment services used by Medicaid members with SUD?
3. How do the new SUD benefit and waiver affect patient outcomes and quality of care?
   a) What is the impact of the availability of substance abuse residential treatment on emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for SUD (e.g. inpatient detox, community-based high intensity residential, and community-based low intensity residential)?

b) Are there spillover effects of the new SUD benefit and waiver on utilization and costs for other physical and behavioral health care services, such as emergency department visits, inpatient admissions, and readmissions for other conditions such as chronic diseases and serious mental illness?
c) What is the impact of the new SUD benefit and waiver on fatal and nonfatal drug overdoses among Medicaid members?
d) What is the impact of the "carve-in" of SUD treatment into managed care plans on health care utilization and the coordination of care with other behavioral and physical health services?

4. How do the new SUD benefit and waiver affect member costs, particularly costs associated with emergency department visits, inpatient stays, and inpatient readmissions?
5. How is the new SUD benefit and waiver related to broader efforts in local communities to address SUD, especially the surge in opioid addiction?
   a) How are SUD clinicians working with other community organizations (governmental, educational, law enforcement, social service) to help people with SUD?
   b) What evidence is there that these "social determinants" are influencing use of SUD services as well as outcomes (e.g. arrest rates, school attendance and performance, employment?)
6. Does the SUD waiver achieve the waiver goals, objectives, hypotheses, and metrics approved by CMS in the waiver application evaluation plan?

Specific evaluation activities

1. Analysis of claims data from Magellan and Medicaid managed care plans

We will use claims data from the Medicaid health plans to examine how member access, utilization, outcomes, and costs related to SUD change following implementing of the new Medicaid SUD benefit and waiver on April 1, 2017 (relevant to Aims 2, 3 and 4). We will require a baseline period of approximately two years, from April 1, 2015 through March 31, 2017. DMAS will need to request health plans and Magellan to provide claims data for all members dating back to April 1, 2015. Specifically, the project will require (1) all emergency department and inpatient hospitalization claims for all members from the health plans; (2) all claims data on outpatient visits from the health plans, including for primary care, specialist visits for physical health, behavioral health, and SUD; all claims data on community-based substance abuse treatment services from Magellan; all prescription drug utilization claims data from the health plans and Medicaid fee-for-service.

Measures of access and outcomes

Figure 1 shows the access and outcome measures constructed from *claims data* that will be used to assess the impact of the new SUD benefit, and how these measures relate to the major provisions of the new benefit.

Access Measures: Examining changes in the number of physicians providing SUD treatment to Medicaid members, as well as the percent of members living in counties with no physicians providing SUD treatment will provide an early indication of whether the increase in payment rates for SUD services, as well as education and training efforts have been successful in increasing the supply and availability of SUD practitioners to Medicaid members. NQF measures on the timely transmission of transition record (#0648), SUD treatment provided or offered at inpatient discharge (#1664), and SUD follow-up after discharge from the emergency department (#2605) will indicate whether efforts to improve care coordination and transition between acute care settings and SUD treatment services are successful.

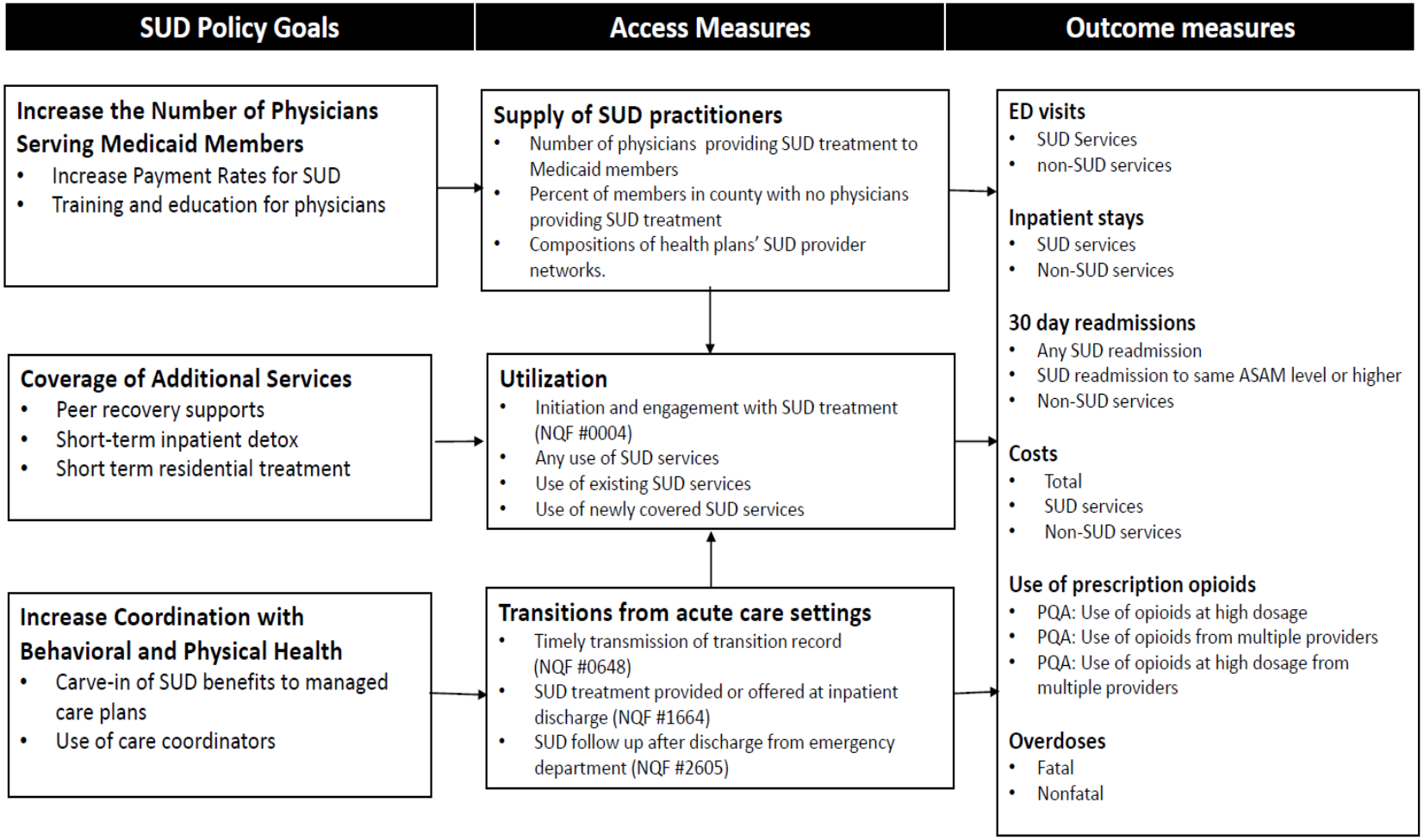
Increased supply of SUD practitioners as well as improved care transitions should result in greater utilization of SUD services, especially initiation and engagement with SUD treatment (NQF #0004). This should also result in greater use of services, especially for the additional SUD services covered by the new benefit.

Outcome Measures: Greater access to and use of SUD services should lead to improved outcomes, including fewer emergency department visits, inpatient admissions, and 30 day readmission rates for SUD conditions. Greater access to SUD treatment and greater care coordination between SUD, mental health, and physical health problems should also lead to reductions in acute-care hospital use for other (non-SUD) health conditions (i.e. spillover effects). Less use of acute-care hospitals should lower the overall costs of care for Medicaid members engaging in SUD treatment. Use of prescription opioids among Medicaid members should decrease along with greater treatment of SUD. Most importantly, it is expected that the new benefit will ultimately lead to decreases in fatal and nonfatal overdoses.

Identifying control groups

Since implementation of the new benefit occurs statewide on April 1, 2017, one of the challenges for this evaluation will be to identify a control group of people who are similar to Medicaid members eligible for SUD treatment, but are unaffected by the new benefit. A control group strengthens the evaluation by allowing us to assess how much of the change in access and outcomes for Medicaid members is likely due to the new benefit, and how much of the change may be due to other changes that are more broadly affecting people in the Commonwealth of Virginia.

FIGURE 1: ACCESS AND OUTCOME MEASURES INCLUDED IN EVALUATION OF SUD WAIVER



Given that the implementation occurs statewide on the same date, it is unlikely that we will be able to identify an ideal control group. Depending on how the rollout of the new benefit progresses., we propose two potential strategies for constructing control groups from existing claims data that leverage either variation in SUD benefit implementation or matching Medicaid members to privately insured individuals.

Differences in SUD Benefit Implementation: It is likely that there will be variation across the state in how rapidly SUD provider networks are established and members begin using services. We can use the regions that are slower in setting up SUD provider networks as a comparison group for the regions that have been quicker to implement the new benefit. Similarly, since the new SUD services will be provided through the health plans serving Medicaid members, there may be variation between health plans in how they implement the new benefit. Such variation between plans could also be exploited for the purposes of identifying control groups.

Matching Medicaid Members and Privately Insured Individuals: We will also consider using people in Virginia with private insurance coverage as a control group. Data on privately insured people can be obtained from Virginia's All Payer Claims Database (APCD), or possibly from the health plans in Virginia that serve both privately insured and Medicaid members. Aetna, Anthem, Optima, and Kaiser Permanente are Virginia health insurance companies that offer plans to both privately insured and Medicaid members.

Analysis to assess impact of the new SUD benefit on access and outcomes

Regardless of the control group(s) that are selected for the analysis, they will likely differ from the "treatment" group (i.e. Medicaid members for whom we are observing the impact of the new SUD benefit) in ways that may affect the measures of access and outcomes used in the analysis, such as differences in age, gender, race/ethnicity, income, community characteristics, and co-morbid mental and physical health problems. In examining the impact of the new SUD benefit, we will assess two different methods for controlling for these covariates.

Difference-in-Difference Analysis: The regression-based difference-in-differences analysis may be more appropriate if the control group consists of regions of the state that are slower to implement the new benefit. The method essentially estimates the net change in access and outcome measures for one group compared to another group, while also adjusting for differences in the characteristics of people between the two groups. An example of how such an analysis would be specified for this project is as follows:

$$Y_i = \beta_0 + \beta_1 REGION_i + \beta_2 POST_i + \beta_3 (REGION_i * POST_i) + \beta_4 X_i + \gamma_c + \varepsilon_{i.}$$

Y_i represents one of the measures of access and outcomes identified in Figure 1, observed for each Medicaid member ($_i$) included in the analysis. REGION is a binary measure reflecting whether the Medicaid member lived in an area of the state that was rapidly implementing the new SUD benefit or whether they lived in an area that was slower in implementation. POST is a binary measure reflecting the time period before and after April 1, 2017 (the implementation date). X_i refers to a set of covariates reflecting individual sociodemographic and health characteristics. γ_c represents county fixed effects that control for time-invariant county characteristics, and ε_i is the error term.

The key parameter of interest is β_3, the difference-in-differences coefficient that reflects the net change in the outcome measure for Medicaid members in regions that are rapidly implementing the new SUD benefit relative to Medicaid members in regions that have been slower to implement the benefit. The analysis controls for other sociodemographic, co-morbid health, and community characteristics that may also be correlated with access and outcomes.

<u>Propensity Score Matching:</u> If we use privately insured persons as a comparison group, Propensity Score Matching is one method that could be used to control for observed differences between Medicaid members and privately insured persons. Propensity Score Matching is a method that essentially identifies a control group of people who have similar characteristics to the "treatment" group. In other words, we would identify a subsample of privately insured people who are most similar to Medicaid members based on their sociodemographic, health, and community characteristics to serve as a control group. Sociodemographic and health data for people would be obtained directly from the claims data, while information on community characteristics could be obtained from the American Community Survey and the Area Health Resource File, both of which provide detailed small area data on population and health system characteristics.

Once the matched control group has been identified, we will compute the change in access and outcomes from before and after the implementation of the new SUD benefit for both Medicaid members as well as the control group (privately insured people who most closely resemble Medicaid members). The effect of the new SUD benefit will reflect the difference between the change for Medicaid members and the change for the control group.

2. Analysis of clinician training and preparations for new SUD benefit

Relevant to Aim #1, the VCU Department of Family Medicine qualitative research team will conduct a rapid cycle quality improvement evaluation of SUD training activities and implementation processes. Data collection and analysis will assess the implementation process in the context of on-the-ground, practice specific settings, with a focus on: 1) describing the SUD benefit and waiver's impact on practice activities and patient quality of life; 2) identifying on-the-ground challenges and facilitators; 3) generating timely and actionable strategies and solutions to inform subsequent phases of provider training and education.

Data collection will consist of key stakeholder interviews, including SUD trainers, clinicians and patients. Practice surveys will be distributed at baseline to obtain descriptive data on practice and patient panel characteristics, use of registries and clinical decision support systems, and existing practice efforts pertaining to delivery of SUD treatment services. Practice site visits will allow for collecting data on practice specific, on-the-ground, conditions and other contextual factors that affect implementation and provider participation.

Baseline data collection will begin in October 2016, with initial provider training expected to take place during meetings of the Psychiatric Society of Virginia in Roanoke, the Medical Society of Virginia in Roanoke, and the Virginia Community Healthcare Association in Richmond. These initial observations will be used to inform the more expansive statewide training, which is expected to begin in January, 2017. A second round of more intensive data collection will occur between January and March, 2017, when statewide training begins. To the extent that additional training occurs later in the year, or subsequent years, then we will consider a third round of data collection.

3. Case studies of selected communities (relevant to Aim #5) – contingent on VCU securing additional funding

Understand community responses to the new SUD benefit; coordination between health practitioners and other community organizations in addressing the SUD problem; how the social determinants of health are related to access to and utilization of SUD services, patient outcomes, and costs.

Select 4-5 communities representing diverse areas of the state. Communities will be selected based on strong potential for addressing social determinants of health, availability of data on social determinants, and in consultation with DMAS.

Conduct interviews with community organizations and groups involved with SUD treatment and prevention, including major health care providers (e.g. hospitals), CSBs, local health departments, schools, law enforcement. Interviews will be designed to elicit information on

perceptions of the SUD problem; the impact of the new Medicaid SUD benefit; community-wide efforts designed to address the crisis; and the key social determinants related to SUD.

Obtain quantitative data on social determinants in the community related to SUD, and examine changes since the implementation of the new benefit.

Timeline of activities

October 1, 2016 to December, 2016

- Qualitative evaluation of initial provider training activities at three provider conferences.
- Begin developing databases and measures to be used for analysis of claims data.

Jan. 2 to June 30, 2017

- Qualitative evaluation of statewide training
- Analysis of baseline claims data from Magellan and health plans

July 1, 2017 to December 31, 2017

- Planning for case studies of the social determinants
- Additional data collection for provider training, if needed.
- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs and patient outcomes during the first 6 months of the new benefit.

Jan. 2 to Sept. 30, 2018

- Conduct case studies to assess social determinants
- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first year of the new benefit.

April 1, 2019 to Sept. 30, 2019

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first two years of the new benefit.

April 1, 2020 to Sept. 30, 2020

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first three years of the new benefit.

April 1, 2021 to Sept. 30, 2021

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first four years of the new benefit.

April 1, 2022 to Sept. 30, 2022

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first five years of the new benefit.

Major Deliverables

- **January 31, 2017.** Report on provider training activities during Fall 2016
- **July 31, 2017.** Report on statewide provider training
- **July 31, 2017.** Report on baseline analysis of utilization, costs, and provider participation before implementation of SUD benefit and waiver
- **January 2, 2018:** Preliminary report on changes in SUD utilization, access, costs, and provider participation during the first 6 months of the new SUD benefit and waiver for Virginia General Assembly.
- **July 31, 2018.** Report on case studies of the social determinants.
- **September 30, 2018.** Report on changes in SUD utilization, access, costs, and provider participation during the first year of the new SUD benefit and waiver for DMAS and Virginia General Assembly.
- **September 30, 2019.** Midterm Evaluation Report required by CMS on changes in SUD utilization, access, costs, and provider participation during the first two years of the new SUD benefit and waiver.
- **September 30, 2020.** Report on changes in SUD utilization, access, costs, and provider participation during the first three years of the new SUD benefit and waiver for DMAS and General Assembly.
- **September 30, 2021.** Report on changes in SUD utilization, access, costs, and provider participation during the first four years of the new SUD benefit and waiver for DMAS and General Assembly, and submission to CMS during negotiations of waiver extension.
- **September 30, 2022.** Final Evaluation Report required by CMS on changes in SUD utilization, access, costs, and provider participation during all five years of the new SUD benefit and waiver.

Key Project Staff from Virginia Commonwealth University, School of Medicine

Peter Cunningham, Ph.D., Dept. of Health Behavior and Policy. Dr. Cunningham will be the Principal Investigator for this project, and will have overall responsibility for project management, oversight of the project budget, and preparation of deliverables. He will also focus on the analysis of Medicaid claims data, and in directing the case studies.

Andrew Barnes, Ph.D., Dept. of Health Behavior and Policy. Dr. Barnes will be a Co-investigator, and will lead the analysis of Medicaid claims data. He is a health economist with experience evaluating the cost impact of substance abuse treatment.

Bassam Dahman, Ph.D., Dept. of Health Behavior and Policy. Dr. Dahman is a biostatistician and will provide statistical and analytical support in the overall evaluation design and in the analysis of claims data.

Rebecca Etz, Ph.D., Department of Family Medicine and Population Health. Dr. Etz will be a Co-investigator, and will lead the qualitative data collection and analysis. She is a medical anthropologist with experience interviewing Medicaid-covered individuals with serious mental illness and substance abuse and working with primary care practices and communities.

Sebastian Tong, M.D., M.P.H., Department of Family Medicine and Population Health. Dr. Tong will be a Co-investigator, and will provide clinical guidance on all aspects of the project. He is a buprenorphine-waivered physician who provides treatment for opioid addiction in primary care and advised DMAS on the design of the Medicaid SUD benefit.

F. Gerard Moeller, M.D., Department of Pharmacology and Toxicology. Dr. Moeller will serve as a consultant for this project. He is an addiction psychiatrist and recognized national expert in research on the clinical aspects of substance abuse treatment.

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5		**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**5-YEARS**
6	**TOTAL EXPENDITURES**						
7	**ELIGIBLE MEMBER MONTHS**						
8	**PMPM COST**						
9	**TREND RATES**						**5-YEAR**
10							**AVERAGE**
11	TOTAL EXPENDITURE						
12	ELIGIBLE MEMBER MONTHS						
13	PMPM COST						
14							
15							
16	**Other Data**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
17	**TOTAL EXPENDITURES**						
18	**ELIGIBLE MEMBER MONTHS**						
19	**PMPM COST**						
20	**TREND RATES**						**5-YEAR**
21				**ANNUAL CHANGE**			**AVERAGE**
22	TOTAL EXPENDITURE						
23	ELIGIBLE MEMBER MONTHS						
24	PMPM COST						

	A	B	C	D	E	F	G	H	I	J	K	L
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**											
2												
3												
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**	
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00 (CY14)**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**	
6												
7	**Medicaid-Eligible Adults in Need of Residential SUD Services**											
8	**Pop Type:**	**Medicaid**										
9	Eligible Member Months					1,105	1,233	1,296	1,350	1,393		
10	PMPM Cost					$6,374.50	$6,724.51	$6,860.55	$6,996.94	$7,136.22		
11	Total Expenditure					$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026	
12												
13												
14												
15												
16												
17												
18												
19												

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Medicaid-Eligible Adults in Need of Residential SUD Services								
Pop Type: Medicaid								
Eligible Member Months		0.0%	-	-	-	-	-	
PMPM Cost		0.0%	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
SUD Waiver Services Recipients								
Pop Type: Expansion								
Eligible Member Months			1,105	1,233	1,296	1,350	1,393	
PMPM Cost			$ 6,374.50	$ 6,724.51	$ 6,860.55	$ 6,996.94	$ 7,136.22	
Total Expenditure			$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid-Eligible Adults in Need of Residential SUD Services	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026
TOTAL	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid-Eligible Adults in Need of Residential SUD Services	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Populations						
SUD Waiver Services Recipients	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026
TOTAL	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026
VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Population Status Drop-Down
Medicaid
Hypothetical
Expansion

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -